The Psychiatric Quarterly

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VALUES AND GOALS IN PSYCHOTHERAPY

BY MELITTA SCHMIDEBERG, M.D.

The history of psychiatry is a pageant of the most varied, and sometimes weird, treatment methods, many of which were propagated with much emotion, and adhered to with dogmatism, and even fanaticism. For the most part, a method ruled supreme until its sway receded, as another innovation arose on the horizon of psychiatry and took a dominant place in medical fashion. Then the old method was buried with discredit—as has already happened twice to hypnosis.[1, 2]

The root trouble is that psychiatry lacks an adequate etiological theory of the neuroses. There can be no scientific treatment, or even scientific evaluation of treatment, unless it can be correlated to an adequate etiology.[3] In spite of the progress psychiatry has made in the last hundred years, it still cannot compare with any other branch of medicine. Every medical specialty is based on a reasonably adequate knowledge of the body in illness and health, and of the mode of functioning of the remedies we apply. This, unfortunately, does not hold true of psychiatry. Even leaving aside the psychoses, the understanding of which is still very confused and very limited, our etiological knowledge—even of the neuroses, which have been intensively studied for the last 50 years —is still rather sketchy.

Current psychiatric opinion can be summed up as follows: Neuroses are caused by, or at least related to, emotional disturbances and conflicts; sometimes to character difficulties or to general instability; to unsatisfactory personal relationships; to emotional hurts and sometimes traumata; occasionally, to somatic conditions, to constitutional factors, and, once in a while, to hormonal disturbances. Social factors seem to play a part, but we are not sure in what way; neuroses can be observed among the rich as well as among the poor. Sometimes they are precipitated by worry, by disappointment and failure, and often by success. We know that unhappy childhood experiences and insecurity play a part, but there are probably a great number of so-called "normal" people who had at least as unhappy childhoods and as great feelings of insecurity as the neurotics.

Most psychiatrists today will agree on the importance of unconscious factors in the causation of neuroses, but one must admit that those same mechanisms, fantasies, and impulses can also be observed in normal persons. We are seriously handicapped in our scientific evaluation of neuroses by the fact that we do not have comparable studies of analytic detail and depth on a large enough number of "normal" persons. But from the writer's own observations, she would say that all specific factors described as etiological for the neuroses can be found in ordinary people too (and probably also in psychotics). Therefore, such factors cannot be regarded as specifically etiological, but perhaps there is a specific combination that determines the outcome, or perhaps there are still other, as yet unknown, factors.

We cannot be satisfied with regarding the difference between neurosis and health in merely accidental or quantitative terms. There must be other factors to account for the differences. For example, it is possible that some less tangible factors help to activate or intensify (like enzymes) the more dramatic ones with which we have been hitherto impressed; or it is possible that it is not so much the intensity of certain factors as it is certain specific combinations of those factors at a given moment that determine the difference between health and neurosis. But should this be the case, then the task of therapy is to develop or to activate these less tangible factors, or to re-arrange the balance of the psychological constellation, besides dealing with the aspects on which we have hitherto concentrated. Possibly many of us already do these things intuitively but are often not aware of them—and as long as we do not know the specific etiological factors, we cannot practise adequate, planned therapy.

A further factor that adds to the existing confusion is that often the therapist himself is quite unaware of which of the things he does or says is responsible for improvement. An analyst may attribute improvement to certain interpretations he gave the patient, when it is actually the effect of sympathy, or of some advice which may have been so trivial that, by the time of writing up the case, he has forgotten that he even gave it. It would be an interesting piece of research to compare in detail, the therapist's and the patient's versions as to what has happened in treatment, though it still would not answer the fundamental question, for what strikes the patient as having been relevant in the therapy is not neces-

sarily what brought on the change in him. But, at least, getting a two-sided version of the therapy in a large enough number of cases would indicate that what appears to be fundamental to the therapist may not even have been noticed by the patient—while some of the things the therapist thought too trivial to remember had a deep effect. We all agree that personality is of paramount importance in psychiatric practice. We know that different practitioners belonging to the same school may achieve very different results, but we know next to nothing about the specific way in which the therapist's personality affects the patient and the therapeutic processes it evokes.

Any etiological theory must satisfy at least the following criteria. It must: (a) explain satisfactorily both the typical features of neurotic syndromes and the individual differences; (b) explain why one individual falls ill under certain circumstances and another person under similar circumstances remains healthy; (c) explain the factors underlying spontaneous recovery; (d) when applied to mental hygiene and upbringing, prevent neuroses, except insofar as they are due to constitutional factors; and (e) when applied to therapy, cure neurotics, or at least explain satisfactorily why it fails to do so. If analytic therapy fails to cure a substantially higher percentage of neurotics than would recover by other methods or spontaneously, then either analytic etiology is faulty, or analytic therapy is not etiologically based—or both.

There is no psychiatric theory at present that can satisfy these requisites and as long as we lack an adequate theory of etiology and treatment, anarchy and dogmatism are bound to prevail. Psychoanalysis was one of the great hopes of psychiatry in this century—as were hypnosis and suggestion in the last—and it seemed for a while as if it would successfully provide treatment and prophylaxis based on the knowledge of etiology.

Freud had rightfully pointed out the limitations of the symptomatic methods prevailing in his time, and the superficiality of the re-educational methods that were then in fashion. He tried to elicit the causes of a symptom in order to remove it, and he achieved impressive results at first, by tracing certain traumata, uncovering unconscious fantasies or emotional conflicts. But gradually disillusionment set in, when the symptoms in apparently cured patients recurred, just as they had recurred in patients treated by other methods. In the face of these disappointments,

psychoanalysts comforted themselves by saying the case had not been treated "deeply" enough, that there had been further, as yet unknown, traumata, or unconscious mechanisms and childhood experiences that had not as yet been uncovered. They decided it was necessary to analyze the patient's whole attitude and character thoroughly, go more deeply into his childhood, break down his defenses further.

This approach was logical; but, unfortunately, its results have not been satisfactory either. Psychoanalysis has been practised on an increasingly large scale for the last 50 years; the length of the individual treatment has become longer and longer, amounting sometimes to five, 10 and even 15 years.

Stricter selection and increasingly high standards have been set in the training and the analysis of the analysts themselves; analytic theory has become more and more elaborate, and analytic publications more and more voluminous. But in spite of all this effort and labor, there is no reason to assume that the results of analytic treatment today are in any way more satisfactory, more lasting or more frequently good than those of 30 years ago—and even the contrary may be true. There is no reason to assume that they are better than the results attained by any other method of psychotherapy or, perhaps, than the results of spontaneous recovery or ordinary human influence.

Increasingly great importance has been attached to the analyst's own analysis, but the hopes based on this have not been fulfilled. Freud himself was so disillusioned here that he recommended that every analyst should be re-analyzed every five years.[4] This suggestion is fraught with so many difficulties that no analytic society ever discussed the applicability of it, or tried to put the suggestion into practice.

Glover[3] seems to assume that, on the contrary, the prolonged analysis of the analyst may have serious disadvantages: "For it is inherently improbable that an acolyte nourished for years on a particular tradition of interpretation will ever have the courage to confess the failure of his training and set about a sound analytic reorientation. On the contrary, he is much more likely to preserve his self-respect by maintaining a fanatical conviction of the special virtues of the traditions on which he has been nourished." And again, "Whatever may be the ideal of training analysis, it is indisputable that the margin of scientific error intro-

duced by factors of transference is extremely wide. It is scarcely to be expected that a student who has spent some years under the artificial and sometimes hothouse conditions of training analysis and *whose professional career depends on overcoming 'resistance' to the satisfaction of his training analyst, can be in a favourable position to defend his scientific integrity against his analyst's theories and practice. And the longer he remains in training analysis, the less likely he is to do so.* For according to his analyst the candidate's objections to interpretations rate as 'resistances.'" (The italics are the present writer's. M.S.)

Adequate statistics of analytic results—based on follow-ups and containing clinical details—have not been published on a large enough scale to draw any conclusions from, so that we have to continue to guess and to rely on chance observations. There is, however, one important statement from the man best qualified to judge. Freud,[4] shortly before his death, reviewed with his customary scientific honesty and frankness his own therapeutic results, openly discussed his failures and disillusionments and spoke very resignedly about the limitations of analytic therapy. It is surprising that this important article has not attracted more attention and has not helped to curb the sometimes extravagant therapeutic claims of some of his adherents.

Though many analysts like to claim to be scientific and research-minded, a single comparison between the traditions of physical medicine and psychoanalysis shows the latter in a rather unfavorable light. Whenever a new method is introduced in physical medicine, its effects, results, failures and dangers are very soon scrupulously checked on a large number of cases by different and unbiased observers before any claims for therapeutic efficacy are made. Yet psychoanalysis has been practised now for 50 years on an increasingly large scale, on tens (or perhaps hundreds) of thousands of patients in many countries all over the world, and it is still impossible to ascertain objectively what its results are.

This is a startling fact, in itself, from which one must draw several conclusions. Glover, in his paper, "Therapeutic Criteria of Psycho-Analysis,"[5] read before the Eighteenth International Psycho-Analytic Congress in London, states, when trying to assess the therapeutic criteria and results of analytic treatment: "But first of all it is necessary to consider the almost unique obstacles that confront anyone who seeks to pursue this investigation, the

most important of which are indeed rarely referred to in the customary symposia on the subject. Pre-eminent amongst these are the sedulously cultivated assumptions that participants in such discussions hold roughly the same views, speak the same technical language, follow identical systems of diagnosis, prognosis and selection of cases, practice approximately the same technical procedures and *obtain much the same results, which incidentally are, by common hearsay, held to be satisfactory.*

"No one of these assumptions will bear close investigation. We have next to no information about the conduct of private analytic practice which up to the present is much more extensive than clinic practice. Moreover, such figures as are published regarding clinic practice would in the majority of cases be rejected as valueless by any reputable statistician, incorrect as they are for methods of diagnosis and selection, for length of treatment, for method of treatment, for after history and spontaneous cure. Indeed, apart from an occasional reference to a case that may have remained well for some years, *we have no after histories worth talking about. Certainly no record of failures. This absence of verifiable information,* when added to the loose assumptions I have already described, *fosters the development of psychoanalytic mystique which not only baffles investigation but blankets all healthy discussion.*

"I have included therapeutic efficacy in the list of unwarranted assumptions, not because I believe results constitute a reliable check on therapeutic criteria, but because a defensive reserve on this subject has *contributed more than any other factor to perfectionist notions regarding the wide therapeutic applicability of psychoanalysis, and consequently to assumptions regarding the criteria of psycho-analysis that are at the same time perfectionist, undefined and uncontrolled."* (The italics are the present writer's. M.S.)

Theoretically, we will have to revise many of our assumptions and re-examine our criteria by means of which we arrive at these assumptions. Analysts are inconsistent as to how far therapeutic results prove their theoretical assumptions. It is claimed that they do not depend on therapeutic results. Yet originally it was regarded as the proof for an analytic assumption that the interpretation explained the symptom and made it disappear. Today, in publications or lectures to outsiders as to how analysts arrive at their conclusions, such simple and convincing examples are still usually

cited. Yet, since analytic theory has become more complicated, and such simple and immediate results are rarely achieved (and are in fact deprecated), and since symptoms are regarded as overdetermined, such simple proofs are no longer available and it is doubtful whether, theoretically speaking, they can be accepted as valid.[6] But the question arises and has to be carefully studied: What are the proofs of our assumptions? It often seems that analysts give convincing examples, and then claim the same credit of likelihood for other assumptions, which they fail to substantiate.* Clinically, if we analysts have no adequate proof for the adequacy of our analytic therapy, we have no right to be dogmatic, either toward our patients, or toward our psychiatric colleagues. In the first place, we have no right to give preference to the "method" over clinical exigencies, as long as we have no adequate assurance that the method is successful in a large proportion of cases: that is we have no right to expect excessive, financial or emotional sacrifices from patients, and no right to stop them from making their

*Glover states: "... The consequence is that a great deal of what passes as attested theory is little more than speculation, varying widely in plausibility. Let me give the commonest instance of this state of affairs. An analyst, let us say, of established prestige and seniority, produces a paper advancing some new point of view or alleged discovery in the theoretical field. Given sufficient enthusiasm and persuasiveness, or just plain dogmatism on the part of the author, the chances are that without any check, this view or alleged discovery will gain currency, will be quoted and requoted, until it attains the status of an accepted conclusion. Some few observers who have been stimulated by the new idea may test it in clinical practice. If they can corroborate it they will no doubt report the fact: but if they do not, or if they feel disposed to reject it, this scientific 'negative' is much less likely to be expressed, at any rate in public and so, failing effective examination, the view is ultimately canonized with the sanctioning phrase, 'as so and so has shown.' In other words, an ipse dixit acquires the validity of an attested conclusion on hearsay evidence only.

"If we now assume that the author is also a training analyst—and it must be admitted that most analysts of moderate prestige and seniority are likely to be training analysts—the process of acquiring untested value is accelerated. Whatever may be the ideal of training analysis, it is indisputable that the margin of scientific error introduced by factors of transference and counter-transference is extremely wide. It is scarcely to be expected that a student who has spent some years under the artificial and sometimes hothouse conditions of training analysis and whose professional career depends on overcoming 'resistance' to the satisfaction of his training analyst, can be in a favourable position to defend his scientific integrity against his analyst's theories and practice. And the longer he remains in training analysis, the less likely he is to do so. For according to his analyst the candidate's objections to interpretations rate as 'resistances.' In short there is a tendency inherent in the training situation to perpetuate error. Such a state of affairs clearly calls for the application of special safeguards."

own decisions* ("in order not to interfere with the analysis").

Nor should the analytic treatment be allowed to interfere seriously with the patient's married life or other aspects of personal life, or to recommend prolonged treatment for minor troubles that could be cured by simpler or quicker methods. Above all, the analyst must not watch calmly temporary "deteriorations" or "regressons" or unfavorable "transference reactions" in the course of treatment, expecting with justified optimism that these will right themselves automatically in the course of the analysis.** The writer has seen too many cases where they have not righted themselves, and the first duty of every therapist is *"nil noce."*

Next, we should be more fair and more open-minded toward our psychiatric colleagues.† There is a tendency among analysts to compare the best in analysis (and sometimes even an ideal that has rarely been attained) with the worst in psychiatry, to some

*A patient of the writer had gone for analysis when she was 28. After a few months she fell in love and wanted to get married. "No decisions during the analysis," said the analyst. She came to the writer at the age of 42, after having had some 10 or 12 years of analysis in the meantime. By that time, her physical appearance and mental condition were such that she had no more chance of finding a husband.

**Glover states: "But we can scarcely expect frankness so long as we foster the tradition that a recommended analysis followed secundum artem ought automatically to succeed—a tradition incidentally which intimidates the experienced analyst as much as it burdens the conscience of the training candidate. It is, moreover, a tradition which encourages the interminable analysis, and with the interminable analysis both clinical and theoretical perspective go by the board. No doubt the analyst's marked reserve regarding his therapeutic results has also been fostered by an earlier need to maintain prestige in the face of the hostile criticisms of non-analytical schools. That was never a desirable reaction and is in any case no longer necessary. Like the desire to turn at all costs a united psycho-analytical front to non-analytical psychology it cripples objectivity at source." (Glover, Edward: Research Methods in Psycho-analysis. Int. J. Psychoan., XXXIII, 1952.)

†In this context, the following passages from the opening address of the president of the International Psycho-Analytic Association, Leo H. Bartemeier, at the Seventeenth International Psycho-Analytic Congress, should be carefully considered:

"Today, ladies and gentlemen, I wish to speak to you briefly about an internal difficulty which interferes with the effective work of many analysts as well as with the acquisition and dissemination of psycho-analytical knowledge. It is a difficulty which interferes with the continuity of our analytical societies, and it is far more serious than any of the external difficulties which have interfered with the growth and development of psycho-analysis during recent years.

"I wish to draw your attention to the fact that many analysts permit themselves to think that they are what their patients in transference endow them with. This problem was discussed by Dr. Grete Bibring in a conference on counter-transference. She pointed out that it is the 'occupational disease' of analysts to develop a disturbance

degree, no doubt influenced by Freud's attitude toward psychiatry. But the psychiatry Freud criticized was that of 50 years ago, and it has since made great strides forward. Also Freud was not unbiased, and not unnaturally he was influenced by the unfair treatment he himself had received. But surely this very old feud should not be perpetuated.

For instance, analysts often speak deprecatingly about short analytic treatment or about suggestive methods, saying that their results are not lasting. How do they know? We have no reliable, really scientifically valid, statistics of the results achieved by any method. Probably the results of short treatment are sometimes

in their reality judgment. *They are accustomed to see themselves through the eyes of their dependent patients, and if a hostile remark is made by the patient they tend to analyze it as a projection. A disturbance in their reality-sense may result from the danger of really believing that they are as their patients think them to be. If someone is wrong, it is usually the patient. Analysts sometimes take this attitude from their consulting room into their everyday social and professional relations.* [The italics are the present writer's. M. S.] This leads to sensitivity and to a tendency to analyse the other person's motives instead of one's own and to the feeling that something important may be destroyed if a mistake is modestly acknowledged. This is bound to lead to difficulties in interpersonal contacts, within the analytic groups and between analytic societies. This is not an ethical but a scientific appeal for awareness that our unconscious is moving all the time and that we should seriously consider some self-investigation whenever such a conflict arises. We would do well to follow the example of our esteemed colleague, Dr. Carl Landauer, who was destroyed by the Nazis. When he felt he found one and the same problem in all his patients within some working day—or when he discovered that certain problems or certain figures did not appear in his day's work—he sat down and tried to find out what it was within himself which interfered with his analytic perception. Every day he worked on his self-analysis according to his daily analytical findings.

"Thus in former days an analyst felt the obligation to scrutinize his sense of reality in connection with his daily work, and I appeal to you today never to give up this daily period of self-investigation, of self-analysis. The nature of the work to which we devote our lives constantly taxes our self-evaluation. We cannot afford to suffer any disturbance to this priceless possession if our work with our patients is to be effective and if we are seriously concerned about the security of our professional organizations." (Int. J. Psychoan., XXXIV, 1952.)

These cogent remarks of Dr. Bartemeier contain many important implications. The writer wants to draw here only one conclusion from them and from the paper by Dr. Bibring that Dr. Bartemeier mentioned. If it is the "occupational disease of the analyst" to develop a disturbance of reality-judgment, then this is bound to affect seriously not only his relation to his colleagues and to the outside world, but to his patients, especially as in this relation it remains unchecked and uncorrected and even unobserved; but its effects are likely to be put down to the patient's complexes, resistances and projections. However, it must interfere both with the accuracy of his scientific observations and recordings and with his therapeutic efficacy.

lasting and sometimes not, just as those of intensive treatment are.*

If we have no reliable proof of the clinical efficacy of analytic treatment, it is impossible to see how one can be dogmatic about applying its methods rigidly. In most analytic orthodox societies very stringent views are held as to how analysis should be practised, a matter which incidentally is a serious handicap to free discussion. But these views vary from society to society, and also differ from Freud's own practice, who certainly never was so "orthodox" and rigid as his adherents. But to urge adherence to these rules merely because the leading analysts lay them down is not a scientific argument.

It is not enough to study the results of analysis quantitatively —to count statistics of cured and uncured patients. But one must examine it qualitatively—determine which of its aspects or therapeutic agents have a beneficial and which a harmful effect. It is possible, for instance, that in cases where indifferent results have been achieved, certain aspects of the therapy were beneficial and others harmful and they cancelled each other out. Some patients improve in certain areas and get worse in others. The problem of whether analytic treatment may cause harm, and, if so, when and under what circumstances, has never yet been investigated, but is, as a whole, dogmatically denied, except for occasional warnings that psychotics or borderline psychotics should not be analyzed.

Any effective agent, whether in psychological or physical treatment, is capable of causing harm, if it is effective enough to cause good. Merely to deny such a possibility is a dogmatic and propagandist attitude, not a scientific one. In clinical practice, one certainly comes across patients who are worse after analysis than before. This may, of course, be due to spontaneous deterioration; but we cannot take this for granted. An attitude that assumes that all patients who are better after treatment are so because of the treatment and that all those who are worse after treatment are so because of endogenous deterioration resembles the principle, "Heads I win, tails you lose." These are matters that have to be carefully examined *"sine ira et studio."*

There seems to the writer to be no clinical justification for insisting that analysis must always be *"carried out pure."* In physi-

*See Freud: Analysis terminable and interminable (Ref. 5). He spoke of two very successful cases that relapsed in later years.

cal medicine, it is taken for granted that the doctor apply, if necessary, several types of treatments or medication simultaneously, that surgical treatment should be combined with medical and supplemented by good nursing, diet and maybe remedial exercises. Similarly, it is often desirable to help the effect of analysis by giving advice, sympathy, reassurance, suggestion, medication, environmental help, and so on. To keep analytic treatment "pure" makes sense only if it is done for research purposes in order to compare it with another "pure" psychiatric method. But such research treatments must be carried out under strict scientific supervision, with careful scientific safeguards, and not as they are usually practised.

The ordinary analyst is a medical practitioner and should treat the patient for clinical purposes, to alleviate his suffering, according to accepted clinical tradition.

As the writer has said, a merely quantitative statistical assessment of treatment results is not enough, though it would be a great step forward to have at least this. But it must also be known how to evaluate it. Two considerations are important. To evaluate the results of any treatment, one should know what the likelihood of spontaneous recovery is. One can regard as a genuine result of any treatment only a proportion of cures that is higher than that of spontaneous remission.

It is very regrettable that there are few observations and follow-ups on psychiatrically untreated neurotics. The observations of intelligent general practitioners are of some interest, but have also, unfortunately, not been collected. It seems that analysts have perhaps been a bit hasty to jeer at the "pink medicine" and "cheer-up" treatments of the general medical practitioners, as they too seem to get results, and certainly with less effort and sacrifice involved than in psychoanalysis. But there are some neurotics, left entirely untreated, who suddenly recover and seem to make adjustments for which most doctors would be only too glad to take credit.* By common agreement, a sizable proportion of psychotics

*Denker, quoted by Eysenck and Glover, found that 72 per cent of 500 cases *not* treated by special psychotherapy recovered within a period of two years, and 90 per cent within five years.

Glover himself has similar misgivings. When trying to evaluate the statistics of results, he makes the following cautionary remarks:

"Even so it would be still an open question whether the 44 per cent credited to psycho-analysis were strictly psycho-analytical results, for in a considerable number of instances the length of the treatment did not exceed five months' duration, a period

improve without any psychiatric therapy, if left alone and just treated humanely. It is, therefore, very likely that a still greater proportion of neurotics is bound to improve, as they have a greater chance than psychotics to be influenced by beneficial life experiences.

The fact that patients get well as a result of analysis, is in itself no proof yet of the efficacy of analysis.* This has always been admitted. It is impossible to eliminate the element of personal relations and indirect suggestion.[6] Different analysts seem to get very different results, probably, to a great extent, because some are capable of establishing better personal relations than others.

which most analysts in this country would nowadays regard as indicative of a prematurely interrupted analysis." He also claims that "staggered analysis" is no different from repeated doses of "short term analysis" and cannot therefore qualify for consideration as a true analytic process. Again, he says: "About twenty years ago, I circulated a questionnaire with the intention of ascertaining what were the actual technical practices and working standards of analysts in this country. Full replies were obtained from twenty-four of twenty-nine members, from the examination of which it transpired that on only six out of the sixty-three points raised was there complete agreement. Only one of these six points could be regarded as fundamental, viz., the necessity of analysing the transference, the others concerned with lesser matters as the inadvisability of accepting presents, avoidance of the use of technical terms during analysis, avoidance of social contact, abstention from answering questions, objection to preliminary injunctions and, interestingly enough, payment for all non-attendance, a ruling which I am glad to say, is sometimes honoured in the breach.

"Since that time and despite many symposia on the subject, there is no evidence that even an approximate consensus of opinion on therapeutic criteria has been reached. On the contrary, even if we exclude such schisms as arise from the plain abandonment of psycho-analytical principals, the tendency to fission within analytical groups in this and other countries, has come to affect more and more the criteria that should govern psycho-analytical therapy." (Glover, Ref. 5.)

*Glover states: "On the issue of interpretation little doubt can exist. Analysis stands or falls on the accuracy of interpretations. It is over twenty years since I pointed out that inexact interpretation, whether therapeutically effective or not, is a form of suggestion. *When therefore any two analysts hold diametrically opposed views on mental mechanisms and content, it is clear that one of them must be practicing suggestion.* Reinforced by transference throughout an analysis of some years' duration, the power of this suggestion must be well nigh irresistible." (Glover's italics.)

Again: "We need not go far afield to find psycho-analytical societies riven by fundamental theoretical differences, with extreme groups holding mutually incompatible views, the opposing sections being held in uneasy alliance by 'middle groups' whose members, as is the habit of eclectics the world over, compensate themselves for their absence of originality by extracting virtue from their eclecticism, maintaining, either implicity or explicity, that whether or not principles differ, scientific truth lies only in compromise. Despite these eclectic efforts to maintain a united front to the scientific or psychological public, it is obvious that in certain fundamental respects the techniques practiced by the opposing groups must be as different as chalk from cheese." (Glover, Ref. 5.)

Prevention has been an equal failure. There are probably as many neurotics today among the children of psychiatrically enlightened and analyzed parents as there were in the most restrictive Victorian times—though probably for other reasons—and the two leading exponents of child analysis, Anna Freud and Melanie Klein, agree that analysis has little to offer in the way of prevention.

If we lack a valid etiology and an adequate theory of therapy, then the only criterion of any given psychiatric method is its clinical efficacy. But, remembering the history of psychiatry—with weird and strange methods that have achieved results and sometimes with the more impossible beliefs getting better results than saner approaches—this is not exactly a comforting thought. That is why the writer has said before that we are back in the dark ages of psychiatry—in the reign of anarchy, in Janet's words[7]—or to be correct, that we have never really emerged from it. Only some of us had — for a short time — the illusion that we had emerged, that we possessed, or were at least in the process of developing, adequate etiological and scientific methods.

It is painful but sobering to lose one's illusions. Our task must be to take stock of what we have learned, both in a positive and in a negative way, to re-evaluate the old findings, to check the dogmas, to re-define the technical terms used, to re-check our observations, definitions and conclusions, to reformulate our problems. But we must also proceed to gather new observations, to experiment with new psychotherapeutic methods, to try to describe them in new terms, and gradually to build new theories which then, no doubt, will be criticized by the next generation in turn.

Merely to enumerate the schools and approaches in the conventional manner, to classify them as re-education, guidance, persuasion, suggestion, hypnosis, hypno-analysis, psychoanalysis and its various schools, analytic psychotherapy, and so forth, is not likely to shed new light on the subject. We should approach the problem as "naïvely" as possible—with as few preconceptions as possible. One such approach would be to take stock of "psychotherapy in everyday life"; to watch and describe the ways ordinary people talk to one another, try to influence, reassure, humor, frighten each other; to watch the manifold little psychological tricks they use in their approaches to each other, the parent or teacher to the child, the shopkeeper to the customer, the employer

to the employee and vice versa, the policeman to the potential troublemaker, the detective to the man he tries to get a confession from; to observe the psychological principles involved in advertising, government, civilizing primitives, reforming criminals, converting people religiously or politically, and so on; and to describe the underlying mechanisms theoretically.

Just as the minor symptoms in the "average" person help us to understand the major neurotic symptoms seen in psychiatric practice, so can the trivial little ways by which people manipulate and influence each other teach us much about what psychotherapy is or should be.

What is the value of symptomatic (that is, non-etiological) methods of treatment? Such methods, of course, have their place in all specialities of medicine, either in the absence of more satisfactory etiological treatments, or to supplement the latter whenever necessary, to lessen discomfort, to prevent emergencies, and so on. The same considerations should apply in psychiatry. But, here in addition, is this peculiar situation: As long as we do not know what method is etiological, if any, we cannot delineate other therapies as being "non-etiological," as "merely symptomatic" or "superficial," and it is possible that some of the methods so described will prove to be more etiologically sound than is assumed today. This depreciation of all methods other than "orthodox" or "deep analysis" is due to the predominance of analysts, who in the last 30 years have risen from the position of the underdog in psychiatry to which they were relegated until the 1920's, and who have by now succeeded in intimidating the other psychiatrists. The belittling of therapeutic results also stems from them: "Anybody can get results." Unfortunately, to get results is not so easy, and does not seem too frequent with any type of school. And though therapeutic results, achieved by whatever method, including analysis, are no proof of an etiological theory, they are of great clinical value. The function of medicine is to alleviate suffering.

To come back to the main point: If the only valid criterion of a therapeutic measure is its efficacy (and not its theoretical justification, since we are not sure any more whether we have an etiological theory to justify, or sure of its "truth," since we do not quite know what truth in psychiatry means), we are thrown back upon clinical standards. This sobering reflection has its compensations. The existing confusion can only be clarified by returning

to clinical values, traditions and criteria. The present anarchy is not due merely to lack of etiological knowledge; much confusion concerns the values and aims of treatment; and it is necessary to restate the most elementary, fundamental traditions of medicine for psychotherapy.

It is usually taken for granted, and indeed is already set forth in the Oath of Hippocrates, that the aim of treatment is to help the patient as speedily, effectively, and painlessly as possible, that considerations of the patient's welfare must come before the interests of research, and that existing methods of treatment must be modified according to individual needs. These obvious truths must be reiterated for psychotherapy, because in this field they have become seriously controversial. To illustrate, the writer has heard therapists speak apologetically about successful cases because results were achieved in a comparatively short time (only several months!), and there was still much the therapists did not know about the patient. On the other hand, the writer has heard it said with satisfaction that a patient became a drug addict or homosexual in the course of treatment; but the therapist took a pride in this because he thought he knew why it had happened. What is more, the writer has heard an analyst say with resignation, if not with cynicism, that his patient was going to commit suicide shortly but that there was nothing he could do about it.

These are, one at least hopes, extreme and exceptional cases, but they are indicative of the trend. What is still more serious, however, is that important analytic groups and schools seem to regard it as an essential and necessary part of therapy, that the patient must get worse,[8] a therapy in which he does not get upset is regarded as "superficial." (However, in some cases this "temporary" and often rather serious aggravation has persisted in the patient 10 years later.) This view is so widely held, in some countries at least, that many of the writer's patients who know of analysis by hearsay, from the analyses of their friends, or from having been with other analysts previously, have seriously reproached the writer on the grounds that she could not be a "proper analyst" as her patients do not get upset but seem on the whole to enjoy the treatment.

Such "Alice in Wonderland" attitudes, so contrary to accepted medical tradition, have arisen from a confusion between therapy and research, originating in psychoanalytic thought. Freud re-

garded it as one of the glories of analysis that it combined research and therapy. What he probably meant was that, had it not been for the fact that he could do research on his private fee-paying cases, he would not have been able to make his discoveries—as, in his time, he would not have been able to get a grant for research. But apart from this historical fact, and in spite of occasional overlapping, it must be kept in mind, that the methods and aims of research and of therapy differ from each other in psychotherapy as much as in any other field. The failure to think these issues out clearly accounts to a considerable degree for the present confusion, which results largely from contradictory values.

Naturally, it is desirable to observe therapy intelligently and draw whatever scientific conclusions seem justified, and, on the other hand, to apply to therapy whatever knowledge has been accumulated. But clinical exigencies must come first, and no doctor has the right to use his patients as guinea pigs, to cause suffering or deterioration or to withhold relief for the sake of research or for the "method."

The word "research" is very glibly used in analysis and psychiatry nowadays, often without any serious realization of what it actually entails. Failure to be a good clinician does not *eo ipso* make a scientist—for example by withholding sedatives or failure to take precautions in suicidal cases. We should keep in mind that the patient comes to the psychiatrist for help, and not to be a guinea pig for future generations, or to serve as a subject for a method; and he usually pays rather high fees for the help he hopes to receive.

The greatest figure in twentieth century psychiatry has been Sigmund Freud. The wish to emulate him seems natural enough, but we should remember that you do not become a genius by copying one; and watching patients' free associations on the couch makes a Freud as little as watching an apple fall makes a Newton. Some take it for granted that by the mere fact of being an analyst one becomes a scientist; this is as little true as that applying the discoveries of Pasteur or Virchow turns a general practitioner into a researcher.

Paradoxically, these attitudes have not only hampered therapy but also stultified research. For all the talk about science, analysts have actually produced very little original scientific work in the

last 30 years.* If the tremendous bulk of published literature were printed without overlapping and reiterations, it probably could easily be reduced to a very few volumes. Too strenuous efforts to emulate Freud killed originality, and the fear of heterodoxy has restricted observation and clear thinking. What was a tremendous discovery 50 years ago, has since become dull and uninspired routine.

Freud had attempted to establish a method of scientific observation, trying to eliminate personal bias and disturbing emotional elements by establishing a sameness of conditions (almost the counterpart of a laboratory) by insisting on a detached, unbiased, and unemotional attitude. The writer will attempt to show in another context that it is impossible to achieve such objectivity and that such pseudo-exactness**[9] not only offers no real protection against fallacies as far as research is concerned; but that the effort to achieve it seriously interferes with therapy, by eliminating humanity and the necessary personal relation. Also, a therapist should have bias—therapeutic bias in favor of normality and health, and the interests of his patient. He should not watch with equanimity and "objective detachment" the patient committing suicide, regressing into schizophrenia, or courting disaster. Unfortunately, Freud's adherents are more royalist than the king, and regard extremes of rigidity and impersonality as the main factors and hallmark of analysis. They insist on putting the method before the patient.

The writer has heard it stated seriously, and she might say almost sanctimoniously, that "the aim of analysis is not to cure the patient"—"that can be done by anybody" (?)—"but to practice the method of psychoanalysis." Many orthodox analysts refuse to utilize non-analytic aids to therapy (physical ones, such as sedation or even laxatives; mental ones, such as advice or reassurance in an emergency), and even forbid or disparage the little ways patients find to mitigate their depression or anxiety. They want to make "pure analysis," "get all the anxiety into the analysis," in

*Glover reports (Ref. 3) on replies to a questionnaire circulated by the international research committee of the International Psycho-Analytic Association to members of the association, asking them to record such of their contributions during the last 12 years as appeared to break *new* ground in psychoanalysis. When the research value of the material was analyzed the proportion of effective contributions could not be rated much higher than 5 per cent.

**Freud speaks deprecatingly about "*Scheinexaktheit*" when he disapproves of producing voluminous notes. (Collected Papers, II. Hogarth Press. London. 1948.)

order to demonstrate that results were brought on by purely analytic methods. Leading analysts have been heard to state that whoever puts the patient before the method ceases to be an analyst; in the writer's opinion, whoever puts the method before the patient is a fanatic and ceases to be a doctor.

Though this attitude is to be deprecated, it has at least a certain logic within the framework of analysis. However, it has been applied since to other forms of therapy, where it just does not make any sense, but serves as an excuse for, and even glorification of, therapeutic failure, lack of clinical judgment and humanity. There is a certain idealization or personification of "analysis" or "treatment" *per se*, a somewhat mystical tendency to assume that "treatment" develops and functions, almost as if it were automatic, once the right conditions are established, and that it is neither necessary nor desirable (and perhaps not even possible) to interfere with this process. Surely this is sophistry, because the "right conditions" mean certain interpretations and behavior on the part of the therapist, continued associations and co-operation on the patient's part. In other words, it is a continuous two-sided process depending on the patient and the doctor, and is in addition influenced by many other factors, such as events in the patient's everyday life, and behavior of the family. It is certainly dangerous to regard "therapy" as a mechanism, wound up and functioning on its own, almost like a Frankenstein mechanism without control. The therapist must take responsibility for the treatment and be in charge of the situation, regardless of whether he lets the patient know this. The "treatment" consists of processes evoked in the patient by the therapist, and the therapist must check, control, and modify them, according to clinical exigencies.

Knowledge and cure do not coincide. We may know a great deal about a man's psychology and yet not be able to help him, and, on the other hand, cures have been achieved (such as in shock treatment) without knowledge of the patient's mind or of the therapeutics of the method. There is also some confusion between (a) the knowledge the doctor should have, (b) that which the patient should convey to the doctor, (c) that which the doctor should convey to the patient, and (d) that which the patient should gain for himself.

Naturally, the greater the doctor's clinical knowledge and experience the better he knows how to conduct a psychiatric examination,

how to elicit information from the patient, how to evaluate the material gained, and how to establish contact with the patient and gain his trust. So, the patient is often blamed for resistance or lack of co-operation or is deemed an unsuitable patient, when the doctor is unable to establish contact and make the patient talk. Again, the doctor often expects too much from the patient, and is unaware of the implied inconsistency: If the therapist believes that the relevant material is unconscious, that is, unknown to the patient by definition, how can the patient reveal it? Very often the patient does not know—and no amount of free association will tell us—what has upset him. It is the therapist's task to discover this. The writer sometimes gets the impression that the therapist acts as if an almost magical omniscience were attributed to the patient's unconscious. Let it be stated, therefore, that there is no more reason to believe that any person's unconscious knows psychiatry or psychoanalysis, than there is to believe that it knows histology or pathology, Greek or Chinese. But even if we credited the patient with possessing such an enviably knowledgeable unconscious, the problem still would remain of how to induce it to divulge its knowledge to us. And this is the task for the doctor rather than for the patient. It cannot be stressed enough that the therapist must take the responsibility for the treatment, must have the clinical knowledge, and skill to elicit the necessary information, and to utilize it therapeutically.

In physical medicine we learn a lot, even from perfunctory auscultation or percussion, because we utilize our general knowledge of anatomy and physiology in evaluating what we observe in the individual patient. The same holds true for psychiatry: We should have sufficient clinical and social knowledge to evaluate and supplement not only what the patient and his family tell us, but to draw conclusions from small details such as how he looks, behaves, where he lives, and the type of job he holds. Often the trouble is not lack of information, but the therapist's inability to utilize it, both for understanding and for therapy. Failure in therapy is so often blamed on lack of information. Actually, one can treat a patient, at least for a time, knowing very little about him, with the aim of trying to improve his condition and the therapeutic relation to the point where the patient becomes able and willing to tell us more. The next issue is: What knowledge should the therapist convey to the patient, or encourage him to work out for

himself? It must be stated here in passing that, by the mere process of free association and lying on the couch the patient is not likely to work out his problems, and gain much more insight than he previously possessed, unless he is helped by the therapist. The writer has seen patients who, in 10 years of free association with another analyst, did not bring up material—perfectly conscious issues—which the writer is likely to ask for in the first or second interview, and others who tried hard to be honest, and merely went around in circles. After all, if the patient could work out things for himself, what would he need the therapist for? True, some people can clarify certain issues for themselves, but others only confuse and complicate them—whether by rumination or by free association—and few go for therapy who are able to help themselves. On the whole, it is generally agreed that self-analysis is of little therapeutic value. But what is the difference between self-analysis and analysis with a silent analyst in the background, except for the fees paid?

Similar considerations apply to "nondirective" therapy. Unless the therapist does something to modify the material or at least change the emphasis, he is likely to remain not only "nondirective" but "nontherapeutic." There is some confusion between nontangible factors, such as contacts or sympathy or subtle influence, like changing the emphasis, and noneffective or nonexistive factors. The mere physical presence of even the mostly highly qualified practitioner is of little intrinsic value. Psychotherapy is not magic; and even a magician has to exert himself.

It throws a strange sidelight on the present state of psychotherapy that Fromm-Reichmann[10] has to argue seriously for two pages that the analyst should not sleep during treatment. Fromm-Reichmann would not discuss this matter so seriously and at such length unless she thought that there were analysts who had to be convinced that it is undesirable for the analyst to sleep during sessions. The present writer has met analysts herself who seemed to see nothing wrong in sleeping or nodding, providing that the patient did not notice it. The question arises: What is their concept of therapy; where do they see the function of the analyst in the process of therapy if they consider it unimportant whether he pays attention or not?

To come back to the main question: What do we want the patient to know, and what therapeutic results do we expect from this

knowledge? We do not as a rule teach a patient suffering from digestive troubles, the histology and physiology of his intestines; or, in any case, we would not expect such knowledge to have therapeutic results. On the contrary, it might upset him and lead to hypochondria.

Why should "insight" or "truth" have any therapeutic value? The "truth" may cure, or even kill—not because it is "true" or "untrue," but because of its emotional tone and effects. In preanalytic times, the therapist or the family usually tried to make the patient forget his worries or anxiety or painful experiences; and there was some wisdom in this. Freud's idealization of the truth and the faith he had in its therapeutic effects reflected his Victorian liberal beliefs. There is, incidentally, a surprising analogy between the attitudes of Freud and Dubois. Freud attacked suggestion and hypnosis for sidetracking the truth and covering up things, showing his pride in his own method, built upon truth, as being not only therapeutically but morally superior. Dubois justified his moral persuasion methods on similar grounds and attacked hypnosis and suggestion in the very same manner. Yet there is a world of difference between the "truth" of Freud and that of Dubois. It makes one think about the relativity of "truth" in psychiatry.

Insight is often equated with making the unconscious conscious and with the undoing of repression; if one sees the main etiological factor in the conflict over repression, deciding the conflict by increasing repression may then be just as effective as the undoing of repression.[11]

Freud gave an alternate description of the function of analysis by stating as its aim: "Where *id* has been, *ego* shall be."[12] In other words, the task of treatment is not so much to make the unconscious conscious, but to make it acceptable to the ego. The writer is very much more in sympathy with this latter approach, which is more human and clinical, than with attempts to ram "insight" of any type down the patient's throat at any cost. Often "insight" is not the patient's insight, but the therapist's preconceived notion of what "insight" the patient should have; and what he dubs "resistance" is really the difference between the patient's and the therapist's version. But even if the therapist is right, how far should he break down the patient's defenses? Defenses are as important to the patient's life and functioning as his skin, and very

often we can help him by providing them or by developing them rather than destroying them.

The writer has never yet gotten a satisfactory explanation from analysts as to exactly what they mean when they aim at "analyzing defenses," whether they try to break them down, to modify them, or to increase them—very important differences obviously. The endeavor nowadays in certain Freudian and also non-Freudian groups is to break down defenses systematically—that is one of the main reasons why patients are getting so upset, a fact which was referred to earlier. What is worse, some seem to deteriorate seriously, and sometimes permanently. The writer herself has seen several patients and heard of more from colleagues, who, after years of analysis, developed open schizophrenia. As is well known, Freud's famous "Wolfman"[13] developed paranoia some years after his analysis with Freud was completed. His subsequent analyst, MacBrunswick,[14] explained this by saying that the previous analysis had made it impossible for him to have an obsessional neurosis, and that, therefore, under stress, he had no other way out but to develop paranoia. It seems to the writer that we should be careful not to remove neurotic defenses unless and until we are sure that the patient can develop other satisfactory and stable ones.

Detailed discussion of his mental pathology may make a patient better or worse, depending on many factors which will be discussed in a later context. But, as a general statement, it may suffice to say that, if the neuroses are essentially emotional disturbances, there is no reason to assume that intellectual knowledge or insight will cure them. True, analysts demand that the patient should accept analytic interpretations emotionally; but they have never explained how intellectual understanding given in an unemotional manner should achieve a beneficial emotional effect. We should consider carefully whether this is not a *contradictio in adjecto,* and whether we do not blame the patient unfairly for his "resistance" when he fails to perform the impossible. The way in which interpretation (that is, intellectual information) is supposed to affect emotions and create readiness to take responsibility and action has never yet been explained, nor has it been proved whether or under what conditions the process is at all possible.

Certainly analysts who tell the patient that they have given him all the knowledge he needs, and that it is now up to him to utilize

it, are making it too easy for themselves and too hard for the patient. It is up to the therapist to modify the patient's emotional reactions effectively and not to reproach him.

Too much is expected from the psychiatric patient as a rule: a degree of co-operation, insight and will power we would not demand from a physically ill patient, yet the psychiatric patient is (by definition) much more disturbed.

Altogether, the writer feels that there is something wrong in the balance of the usual patient-therapist relation in psychotherapy. The therapist takes far too little responsibility. For exacerbations during the treatment, he blames "treatment"; for therapeutic failures, the "resistance" of the patient or the family; but for the successes, he presumably takes the credit. In addition, he safeguards himself by careful selection, by dwelling on the difficulties of each case, by accepting only those in favorable circumstances, willing to co-operate and likely to recover, rather than those more seriously in need of help. The writer feels that the therapist should take more responsibility, and on the other hand, make co-operation for the patient easier by giving him confidence and encouragement.

An inconsistent attitude concerning the patient's will power is also implied: As far as the patient's ordinary functioning is concerned he is told that his unconscious is responsible for success and failure, and his belief in his ability to make rational decisions and carry them out effectively is rather undermined. Yet an extreme degree of will power and responsibility is expected from him in the doctor-patient relation; and the fact that the therapist himself is so reluctant to take responsibility sets a bad example for the patient. It seems to the writer that the therapist should do more to develop the patient's will power in therapy and not crush him by making excessive demands as to co-operation, that he should take more responsibility himself and by so doing, set the pattern for a favorable identification; that he should avoid disparaging the patient's actual functioning and the manifestations of will power in ordinary life; but, on the contrary, that he should build up the patient's self-esteem and confidence by dwelling on his achievements.

There is also much confusion concerning the aims of therapy. This is due to: (a) unreal concepts of normality and cure, a disparagement of partial successes, and the failure to consider the

degree of results likely to be achieved in the individual case, either because of the patient's condition and clinical type or his circumstances and environment; (b) conflicting ideas as to whether loss of symptoms is desirable or dangerous; (c) whether it is desirable, necessary or justified to change the patient's whole personality, personal relations, mode of life, and so on, whether such far-going changes can be achieved without imposing one's own values; (d) and whether results achieved in long treatment are necessarily better than those achieved by short treatment, and whether there is any danger in short treatment.

The writer has discussed elsewhere the "myth of the fully analyzed patient" and the quite unreal ideas about normality held by many analysts,[15] and has expressed regret that there were no satisfactory follow-ups or detailed clinical studies of normality to check these therapeutic fantasies. She can only add, that in the 20 years since this article appeared, much has been published concerning aims, methods, and the working of analytic therapy, but little clinical observation of actual results has been made.

There is a fear that symptoms may disappear because of increased repression and that loss of symptoms may drive the illness underground and actually make the patient worse. This may, of course, happen, and it requires clinical knowledge to observe the process in time. There is, however, no reason to believe that it happens more frequently as a result of short treatment than of long treatment, or as a result of suggestive treatment than of analysis; and there have been a number of patients who became schizophrenic after long analysis. Interpretations and the systematic breaking down of defenses are more likely to upset the patient's balance* and to push "borderline cases" into open psychoses than are reassurance and guidance.

Again we should keep in mind the clinical fact that the patient comes to us for help because he wants to get rid of the symptoms from which he suffers; this should be our first and main concern; and we should use our clinical knowledge to watch that the patient's general condition does not deteriorate while his symptoms improve. It seems to the writer that all these problems can only be solved in the light of clinical knowledge and observations, and not by theoretical speculations.

*Note MacAlpine's discussion of regression (Ref. 8) produced by the transference situation.

Is there any reason to assume that therapeutic results achieved by long treatment are inherently more valuable than those achieved by short treatment,* even if clinically both appear the same? Should long, or intensive treatment be the method of choice for every case? This recalls a word by Mr. Churchill, when during the war there was discussion as to whether time was on the side of the Germans or the Allies. "Time," he said, with his usual common sense, "is on the side of the one who makes the most of it." What actually happens in treatment matters more than the length of time spent.**

However, some qualifications must be added: There are, from the pragmatic point of view, three types of treatment:

(1.) The one that is probably most frequent is the type where very little actually happens, and which just continues to drag out and eventually dies a natural death—either because both the therapist and the patient get bored and resigned, or because the patient's money runs out. Sometimes they both try to save face and agree that something did happen in treatment. To justify long treatment there must be steady and considerable improvement. The writer herself has not yet encountered a case where, after a long stagnation, there was an almost miraculous, sudden improvement. It is to be feared that miracles are rare, and that this type of happening is more frequent in the realm of legend than of fact, though, of course, it may occur with or without treatment.

(2.) A type of treatment, also more frequent than is usually believed, is the one where the patient is getting worse. However, this is often not recognized; but it is assumed that these "temporary aggravations" are an essential part of therapy, are even good signs, or, alternatively, are due to an inherent deterioration of the patient, and that, without therapy, the deterioration would have been worse. To recognize the ill effect of treatment at an early date is very important; but, to do so it is necessary that the therapist should not be a fanatical adherent of any given method,

*"Analysts ... by their somewhat envious depreciation of the results of short term work which are held, quite erroneously in many cases, to be impermanent. These are matters that can be determined only by statistical control." (Glover, Ref. 3.)

**As regards length, which is frequently but erroneously held, especially by those who conduct analysis of four to five years' duration, to be equivalent to depth, it is perhaps sufficient to say that the whole problem is at present completely prejudiced by the analyst's tendency to justify stagnant and stalemate analyses: for however bright its beginnings the interminable analysis ends ignominiously as occult transference therapy." (Glover, Ref. 3.)

and that he be able to tolerate the hurt of his therapeutic narcissism. The therapist in this situation also needs good clinical experience and diagnostic knowledge. It is a great advantage if he is master of various therapeutic techniques; for, if the patient reacts badly to the therapy, one cannot just blame him for his "resistance"; it is necessary to modify the therapy, or stop it, but stop it in such a manner that the patient is not hurt by the stopping. It does not help a patient who has a low self-esteem anyhow, if, in addition to his other failures, he is made to feel that he is also a failure as a patient, when other patients are supposed to have succeeded.

(3.) Now one comes to the patients who really do improve in therapy. Even an initial improvement, however, does not necessarily justify indefinite treatment;* to justify that, there must be steady improvement; and, even then, the advantage and drawbacks of continuing must, after some time, be carefully weighed. In physical medicine, we know that there is an optimum for every therapy. We do not assume that because digitalis is good, more digitalis is necessarily better. On the contrary, it may kill the patient.

We know in medicine, or at least try hard to find out, (a) the probable results that any given therapy is likely to achieve in any given case; (b) its optimum application; (c) the possible drawbacks and dangers of each type of treatment and how far such dangers are likely to arise from a more intense or prolonged treatment; and (d) the early danger signals. We do not keep a patient in treatment for years to prevent a later relapse or new illness, but let him lead as normal a life as he is capable of, and deal with a new emergency if and when it arises.

Unfortunately, in psychotherapy, we not only lack this type of clinical knowledge, but we have not made any serious attempts to acquire it, and have not tried to observe our therapeutic methods and results in an unbiased manner. Psychotherapists seem more sensitive than other doctors.

The very unrealistic notions widely held about normality and the objectives of treatment, and the sad lack of follow-up cases, were discussed earlier. To decide objectively the question of

*"When coming to a decision on this question of length it would be well to remember that the earlier analysts were accustomed to conduct analyses of six to twelve months' duration which as far as I can find did not differ greatly in ultimate result from the results claimed at the present day." (Glover, Ref. 5.)

whether in most cases long treatment is desirable, we would need a sufficient number of cases treated by both short and long therapy, followed up and assessed by both psychiatric examination and psychological tests. Failing such systematic assessments—and the writer is not impressed with the arguments about why these should be so difficult to establish—there are two considerations. First, all analysts have themselves been analyzed and are therefore "known" patients. There would be no difficulty in assessing their mental conditions by means of psychiatric and psychological examinations, and in comparing the results with those made on persons of similar type who have not been analyzed, that is, other doctors. Second, the writer must fall back on her own personal observations.

She has treated about 20 patients who had had between three and 11 years of analysis, many with prominent analysts, before they came to her; there was a much larger number who had had analysis for less than three years. She has also seen about 100 persons either in consultation, or known personally or socially, or known of intimately—as in the case of marital partners of her own patients—who have been analyzed over long periods by Freudian analysts, many of them well-known. She has also discussed these matters with other experienced analysts, some of whom have given her very honest opinions concerning their own cases and those of others seen in consultations or otherwise. The general impression was certainly not that these long-term patients were better adjusted than patients treated over short periods or than ordinary persons who had never been treated. Some of those who came to the writer for further treatment were very poorly adjusted, and even very ill—in a number of cases worse than when they had started their first treatments.

There is no merit to "treatment" as such: It may help or hurt or confuse. It is of value only if it helps. Nor does previous treatment make the task of the second (and very often he is not the second, but sometimes the fifth, sixth and more!) therapist easier. On the contrary... ! The writer's clinical impressions are of course not conclusive, but in the absence of sorely needed scientific surveys, she considers them important. However, the following considerations will reinforce them. It is known that every type of treatment, even if it is purely physical, affects the patient psychologically after a prolonged period. He often becomes worried,

hypochondriacal, resentful, fussy, full of grievances. Sometimes even one to two years' stay in a tuberculosis sanatorium is sufficient to change the patient's mentality unfavorably. This is more likely to take place in the case of psychiatric treatment.

There is such a thing as hypochondria of the mind, the patient tending to watch and to worry about any change of mood or mental reaction; and the more he concentrates on his changes of mind, the more worried he gets. It is, of course, easy for him to produce painful states of mind and symptoms to justify his worries. Psychiatric treatment that makes the patient concentrate on his mind —and analysis still more—is likely to intensify such reactions. Also to be a psychiatric case is a serious blow to a man's self-esteem, and this fact alone makes him doubt his normality, especially if his friends or family quarrel with him and call him "crazy" because he is a psychiatric patient. The more intense the treatment, as to length, the number of sessions, the degree of sacrifice it demands, and the emotional involvement it creates, the more intense are these effects. If a patient spends a third or more of his income on analytic treatment over a period of years, as frequently happens, this is bound to interfere with normal living; but apart from the practical considerations, the psychological impact of the fact that he must be very abnormal to need treatment requiring such sacrifices, affects the patient's self-esteem, creates resentment in his wife, and so on.

Also, the treatment—and more so if it is intense and the patient is emotionally involved in it—isolates him from normal life and from friends from whom he has to hide his "transference," and so many of his psychological preoccupations. True, some patients compensate by transforming this situation into one of feeling superior because they are being analyzed. This feeling of superiority is pleasanter to the patient, but undesirable therapeutically. The aim of therapy is to make the patient "normal," that is, ordinary, and not to give him ideas of grandeur; it should help to put him in touch with ordinary life and interest him in normal activities, not create barriers. But the worst aspect is the patient's dependency. This is of course well known, and was one of Freud's main criticisms of the suggestive methods.

Analysis claimed that it did not make the patient dependent because it analyzed the transference. This was well and good as long as the average length of analysis was three or six months,

but if analysis lasts five and 10 years or more, it is bound to create a situation of dependence. Also, it has not been proved that analyzing the transference diminishes it; it may intensify it. Analytic patients often have an amazing dependence on the treatment,*[16] with the result that they are unable to make their own decisions, however trivial, without having them "analyzed" first; that they continue treatment for many years, sometimes making excessive sacrifices for it; and that they do not mind that treatment interferes with their normal lives and personal relations. Also, they have an impressive evaluation of psychoanalysis, written with a capital "P," and are excessively sensitive to anything resembling even a harmless criticism of it, even if they do not have a very personal attachment to the analyst.

Apart from the transference, there is also the conditioning. Most neurotics are timid, often suffer from indecision, and are afraid of life. If they get conditioned through treatment over a period of years, always to watch their mental reactions, always to find

*C. P. Oberndorf, in his paper, "The role of anxiety in depersonalization," (Int. J. Psychoan., XXXIII, 1950) mentions the case of a man of about 40 who "had been under treatment, a supportive modified analysis, by the same analyst daily for fifteen years. Then terrible anxieties developed in the patient over the possibility of his physician's failing health in advancing years. The latter thought it futile to go on with the patient and arranged that he continue under the care of a younger psycho-analyst. According to the patient the old physician, with his increasing irritability, became tired of his complaints and 'practically threw him out.' To quote from the patient, 'The fact that the treatment had continued fifteen years made the actual facing of reality if the doctor abandoned me that much more horrible, and made his lack of any true feeling for me more apparent... That Dr. X should leave me alone to carry on my existence released a surcharge of anxiety so overwhelming that I was unable to comprehend the feelingless state in which I began to live. Then I was driven to desperation—ceaseless, unknown, which led to actual death attempts.'"

For the next three years the patient had been treated by two psychoanalysts, after which he came under Dr. Oberndorf's care, and here the story stops. This patient started treatment in his early 20's, probably a still very immature personality and therefore ready to be a dependent, passive homosexual, and spent almost half his life in intensive daily treatment. It would be interesting to know what happened to him eventually.

That the treatment was unsuccessful is shown by the very bad condition in which he was for three years before he came under Dr. Oberndorf's care—after 15 years of analysis. But it is revealing that "with the relief of anxiety through reassurance at an almost infantile level by means of a playful jocular attitude on the part of the therapist, the sense of feeling has in a measure returned." (One of the patient's main complaints had been his depersonalization.) This last remark by Dr. Oberndorf makes one think that a different, more easygoing thearpeutic approach, rather than analysis, might perhaps have produced better results—it certainly could not have been more ineffective!

out the reasons for all their actions and reactions before acting, and if they are warned against a "flight into reality" or "into health," this situation is bound to interfere seriously with all spontaneous feeling and activity, and with becoming self-reliant. Most patients, after 10 years or so of analysis, remind one of persons who have spent years in institutions, either jails or tuberculosis sanatoria: They have the same anxiousness and fear of life; the most trivial thing becomes a matter of momentous decision, and they feel different from others.

In the case of the neurotic this condition is made worse by the fact that he does not realize that his peculiarities are to a large degree the effect of the prolonged treatment situation, and of the unnatural life he has led, but thinks they are an indication of his own abnormality and indicate a need for further treatment. The writer has a patient who was in analysis from the age of 19, until he was 34. When he first went for treatment, before he came to her, he was very neurotic, inhibited and immature, coming from both an emotionally and socially poor home. When he came to see her, he was in a condition resembling schizophrenia. She pointed out to him that he had never had the opportunity to lead a normal life, that first his parents, and then his treatment, gave him a fear of life, that he never took the normal steps toward independence, that he never took any credit for normal achievements and development, but attributed these to treatment, that having been an eternal patient he thought of himself as being crazy, and then tried to live up to that idea of himself. She encouraged him, improved his self-esteem and initiative, pushed him into more activity and he became substantially normal in a surprisingly short time.

On the basis of sufficient clinical experience and by assessing the patient's life situation, we should be able to foretell the degree to which he is likely to approach the normal, and there is no point in having intensive treatment over indefinite periods with patients who are not likely to reach the high level of health we may wish for them. Many such patients would do better if they were treated for relatively short periods whenever they break down, or are on the verge of breaking down—and in the meantime allowed to live as nearly normal lives as they are capable of. Others might be kept going, or at least kept out of institutions, if they were seen, say once a month and in emergencies, as long they lived. We are not likely to get absolute results. We must be realistic in our aims

and elastic in our methods. We should try to work out the best compromise for each case, weighing the advantages and disadvantages of treatment. We should also give some thought to the fact that most cases in private practice are seen at least several times a week, and most nonpaying patients at very much less frequent intervals, yet it is not certain whether the recovery rate among the former is really higher than among the latter.

Psychotherapists have a somewhat ambiguous or deprecating attitude toward therapeutic results, especially if they have been achieved within a short time. There is some feeling that the therapist should be above such simple and unscientific realities as results—this is part of the previously-discussed confusion between therapy and research. The therapist is also influenced by the idea, originating from psychoanalysis, that he should have no values or aims but be objective and detached; yet, obviously, it is impossible to do effective therapy without having the definite aim of curing the patient, and the values and traditions of a doctor. This is important for more than one reason. We always claim, the writer believes with justification, that children sense and react to the attitudes of their parents; and, in the same way, patients react to the attitude of the therapist. Results nowadays seem to take longer than they did 30 years ago; the writer believes this is largely because the patient senses the therapist's ambivalence toward his improvement. The therapist wants him to get better but not too quickly—and he may even be confused about that. The therapist probably disparages early improvements, and the patient reacts to these attitudes obligingly enough.

It has been claimed that much of what appears to be improvement is only temporary or partial, and not likely to last, or is a "flight into health" or "pseudo-cure," "resistance to treatment," "covering up deeper layers," and so on. There is probably often some truth in these statements, but this truth is put to the wrong purpose. Improvement usually comes in steps, some improvement here or there, with intermittent setbacks, but that does not diminish its value. It is very rare indeed, if it ever happens, that cure comes suddenly and fully after a long period of stagnation. But it is very bad to disparage early improvements, as very often there will be no further gains if the initial ones have been crushed. If the timid patient's tentative efforts to assert himself or to test reality are disparaged, he may not try again; and no patient can

improve without hope and confidence. The concept of "pseudo-cure" makes no sense to the writer at all: No cure, achieved by whatever method after however long a time, holds a guarantee of permanency, and improvements may be of varying degrees of stability, but mostly we can evaluate their stability only in retrospect. "Resistance against treatment" or "flight into health" by getting well, seems a very healthy and understandable reaction. Who would blame a patient who has been bedridden for a long time wanting to walk again? That apparently normality may be a defense against deeper conflicts or fixations is probably only too true; but unless and until we have detailed examinations of really cured or spontaneously normal persons that rule out such mechanisms, we had better accept such normality as actual and desirable.

An important implication is the problem of how cures are derived; do we cure the patient by eradicating his deeper conflicts, fixations and abnormality, or by increasing and stabilizing his potential normality? In the writer's opinion, we have to work in both directions, and so often the attempt of trying to isolate and to combat the patient's abnormality has serious ill effects because these attempts crush his potential or growing normality, and also because the efforts to isolate his abnormality often focus or intensify it in an undesirable manner.

To sum up: The present "anarchy in psychotherapy" is partly due to the lack of adequate etiology and to many preconceived and probably unsubstantiated views concerning therapy, but also, very essentially to a confusion of values and aims of therapy.

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USE OF RESERPINE (RAU-SED) IN THE TREATMENT OF THE SENILE AND CEREBRAL ARTERIOSCLEROTIC PSYCHOTIC*

BY NATHAN BECKENSTEIN, M.D. AND L. SECORD PALMER, M.D.

The rate of admissions to mental hospitals of patients with psychoses due to senility or cerebral arteriosclerotic states has accelerated as the increasing life span has raised the ratio of the older age group to the general population. In the United States in 1900, four of every 100 persons were 65 years of age or older; today the rate is almost eight of every 100. The New York State Department of Mental Hygiene annual report of 1953[1] indicates that the first admissions of patients with psychosis with cerebral arteriosclerosis amounted to 22.8 per cent of total first admissions for that year. The number of arteriosclerotic first admissions per 100,000 of general population was 23.8. These figures compare with a total percentage of arteriosclerotic first admissions in 1912 of 2.9, and with 1.8 arteriosclerotic first admissions per 100,000 of general population in that year.

The corresponding figures for first admissions with senile psychosis were: 1912, first admissions 10.4 per cent, with 6.4 such admissions per 100,000 of general population. These figures for 1953 were 16.2 per cent of first admissions and 16.9 first admissions per 100,000 of general population.

There is, therefore, understandably heightened interest in procedures that will effect improvement in, or that will alleviate the symptoms of, the various forms of senile and arteriosclerotic psychiatric disorders.[2]

Medication which offers promise of improving the patient's condition, with or without the use of other forms of therapy, is of particular interest in the face of the rising tide of admissions, with consequent overtaxing of hospital facilities and staff.

On the basis of many favorable reports[3] in the literature on the use of reserpine in mental disorders[4] in general and in the treatment of senile and arteriosclerotic[5, 6] conditions in particular, it was decided at Brooklyn (N.Y.) State Hospital to administer it to two small groups of patients with senile and arteriosclerotic

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The reserpine (Rau-Sed) was supplied through the courtesy of E. R. Squibb & Sons.

illnesses, to determine its efficacy. In addition to determining changes in the patients' mental conditions, it was decided to note briefly to what degree, if any, the use of reserpine would make possible the elimination of other, concomitant therapy previously employed.

Reserpine has been reported to have a sedative and tranquilizing effect which results in improved mood and better social adjustment, making the patient more receptive to psychotherapy.

Cases were selected from both male and female infirmary services.[5] Criteria were that the patients be in the older age groups, that they be disturbed, un-co-operative with all modalities of care and treatment, and that they be difficult to handle by hospital personnel. Those selected and their diagnoses are shown in Table 1.

Table 1. Distribution According to Diagnosis

Diagnosis	M	F	T	Per cent
Cerebral arteriosclerosis	10	9	19	33.9
Senile psychosis	7	7	14	25.0
Involutional psychosis	1	11	12	21.4
Dementia praecox	1	5	6	10.7
Psychosis with psychopathic personality	..	1	1	1.8
Manic-depressive psychosis	..	2	2	3.6
Psychosis with epilepsy	..	1	1	1.8
Psychosis with alcoholism	1	..	1	1.8
Total	20	36	56	100.0

Throughout this study, reserpine (Rau-Sed) was administered orally, in tablet form, without resort to intramuscular administration, to two groups of patients. This first group consisted of 20 chronically disturbed psychotic men, aged 58 to 90, with an average age of 73.8. Reserpine was administered from six to eight weeks without any of the other medications usually given in this condition. Duration of illness before admission to the hospital varied from five days to 5 years, with an average of 1.45 years. Because of the general debility of the group, low dosages were used. The initial dose of 1 mg. daily, orally for one week, was increased to 2 mg., given as a single dose or in divided doses twice daily. It was reduced to one-half or one-fourth of the initial dose in cases of excessive drowsiness. Blood pressure readings were taken routinely twice weekly. Reduction of blood pressure did not require

discontinuing reserpine in any case. There were 10 cases in the group in which the blood pressures ranged from around 150/90 to 176/100. These pressures were reduced to averages of 140/85-95. Ten other cases showed no elevations in blood pressure and were not affected by reserpine.

Of the first group of 20 men patients studied, five showed marked improvement with decided amelioration of symptoms, seven others improved, and eight showed no observable changes. Improvements consisted in the lessening of anxiety-laden reactions to phobic ideas, thus making patients more amenable to psychotherapy, occupational therapy and recreational therapy. They became quieter, more co-operative, and physical restraints hitherto used, such as the camisole or protection sheet, were no longer required. Barbiturates for sedation were found to be unnecessary. Patients were more easily managed by ward personnel. This improvement does not coincide with the definition of much improved and improved as used by the New York State Department of Mental Hygiene's *Statistical Guide* for purposes of convalescence. Although response to reserpine therapy has been reported to follow a pattern of sedative, turbulent and integrated phases, no turbulent phase was noted in either the male or female cases.

The second group under study consisted of the 36 mentally ill women patients whose condition was characterized by assaultive, un-co-operative and destructive behavior. Their ages ranged from 49 to 84, with an average of 66. Reserpine, 1.0 mg., twice daily, was administered for a period of three months. The average duration of illness in this group of patients before admission to the hospital was 6.37 years.

Table 2. Distribution According to Age

Age	M	F	T	Per cent
51-55	..	6*	6	9.5
56-60	2	6	8	14.5
61-65	3	6	9	15.5
66-70	3	5	8	14.5
71-75	..	7	7	12.5
Over 75	12	6	18	33.5
	20	36	56	100.0

*One of these patients was 49 years old.

As in the first group, following reserpine, it was possible to discontinue all other sedation completely. Previously 26 of these women patients had received sedatives three times a day during waking hours, and 14 patients had had sedatives every four hours at night. Electric shock therapy, previously administered to eight patients, was discontinued the day reserpine treatment was initiated and was not needed again. Four of these eight improved and went home; and the reserpine was then dispensed with entirely. It was noted that the incidence of accidents in the group of 36 women (one to two a day before this study) fell to an average of one a week after the start of reserpine therapy.

Aggressiveness, combativeness and the frequency of hallucinations were markedly reduced. Improvement was characterized by a considerable decrease in tension and hostility and by increased interest in social activities. Eating and sleeping habits improved. The quality of patients' work in occupational therapy improved; attendance at religious services became more regular; and there was definite memory improvement. Patients evidenced greater interest in themselves and their surroundings and were, in general, more co-operative and more easily managed by ward personnel than before.

Although blood pressure fell in some hypertensive patients, it was not necessary to discontinue reserpine. There were 15 of these patients who were definitely hypertensive before reserpine therapy was instituted. Eleven of these showed definite reductions in hypertension, from a high of 210/110 to a low of 150/90, with an average before reserpine of 170/105 for the hypertensive group; the remaining four did not improve. The other 21 patients, who had normal blood pressures before reserpine therapy, showed no significant decreases in blood pressure after it. There was no evidence of liver damage or other toxic effects in either group.

Of the 36 patients in this group of women, 10 showed marked

Table 3. Results With Reserpine Treatment

Groups of patients	Much Improved		Improved		Unimproved	
	No.	Per cent	No.	Per cent	No.	Per cent
Male	5	25	7	35	8	40
Female	10	27	11	27	15	46

Table 4. Improvement According to Age

Age	Much Improved			Improved			Unimproved			Grand Ttoal		
	M	F	T	M	F	T	M	F	T	M	F	T
51-55	..	..	..	..	1	1	..	5	5	..	6	6
56-60	..	2	2	2	2	4	..	2	2	2	6	8
61-65	..	2	2	1	2	3	2	2	4	3	6	9
66-70	2	1	3	..	2	2	1	3	4	3	6	9
71-75	..	2	2	..	1	1	..	2	2	..	5	5
Over 75	3	3	6	4	3	7	5	1	6	12	7	19
Totals	5	10	15	7	11	18	8	15	23	20	36	56

Table 5. Improvement According to Diagnosis

Diagnosis	Much Improved			Improved			Unimproved		
	M	F	T	M	F	T	M	F	T
Cerebral arteriosclerosis	3	5	8	3	4	7	4	3	7
Senile psychosis	2	3	5	2	4	6	3	..	3
Involutional psychosis	..	1	1	1	1	2	..	7	7
Dementia praecox	..	..	..	..	1	1	1	3	4
Psychosis with psychopathic personality	..	1	1	..	..	..	..	..	..
Manic-depressive psychosis	..	..	..	..	..	..	..	2	2
Psychosis with epilepsy	..	..	..	..	1	1	..	..	..
Psychosis with alcoholism	..	..	..	1	..	1	..	..	..
Totals	5	10	15	7	11	18	8	15	23

Table 6. Convalescent Care According to Age, Diagnosis, Condition and Duration of Illness in Females

Age	Diagnosis	Condition	Duration
64	Involutional psychosis	Improved	6 months
66	Cerebral arteriosclerosis	Improved	1 year
75	Senile psychosis	Improved	1 year
58	Cerebral arteriosclerosis	Much improved	3 months

psychiatric improvement while on reserpine, 10 moderate improvement and 15 no improvement. Four of these women were considered and approved for convalescent care. One of these four was much improved; three were improved.

After completion of treatment, and without relationship to it, 10 patients died, nine men and one woman. One male was 59 years old; the other men and the woman ranged in age from 76 to 83.

Five men and the one woman were cases of senile psychosis; the others were suffering from cerebral arteriosclerosis. The durations of illness in these patients before admission averaged 1.19 years. The woman had been ill 2.5 years before admission. The senile patients had longer periods of hospitalization than the arteriosclerotics. Death occurred in less than 10 months after admission in eight of these patients. One man who died had lived three years and 10 months after admission; the woman had lived in the hospital five years and 5.5 months. All of the deaths, except one, were due to cardiovascular disease. In the other case, a man died of bronchopneumonia.

Summary

Reserpine was administered orally to two groups of disturbed and un-co-operative patients with psychoses in the older age group in Brooklyn (N.Y.) State Hospital.

Reserpine in comparatively small dosage, not exceeding 2 mg. daily, resulted in better control of the more troublesome symptoms in many of these elderly patients. Irritability, agitation, assaultiveness, un-co-operativeness and hostility were markedly lessened, and patients became more outgoing, co-operative and amenable to psychotherapy. In both groups, use of all other sedatives was discontinued; physical restraints were no longer required, and accidents were reduced in frequency. In the women's group, electric shock therapy was discontinued. The work load of the nursing and other ward personnel was considerably lightened. Following reserpine administration, patients with whom contact was previously difficult or impossible, became receptive and congenial, responding to what was being done for them. Throughout the study, no toxic effects were noted in either group.

From this study, it appears that reserpine is useful in the practice of geriatric psychiatry. By its favorable effect on disturbed states, it may help to ease the burden that is brought about in a busy mental hospital by today's increased admission rates, especially where there may be overcrowding and a limited staff. It is hoped that further research with reserpine will make possible the reduction of the use of electric shock therapy, with its hazards to the aged patient and its need for special groups.

It is hoped also that, with the use of drugs like reserpine in private psychiatric practice, more aged patents may be made

amenable to therapy at home, reducing the need for hospitalization.

While, thus far, one cannot speak in terms of recovery in these cases, it is gratifying to know that agents are now available which can help to make these older patients more comfortable.

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RAPID SCREENING OF PHRENOPRAXIC DRUGS*

BY ANTHONY SAINZ, M.D., NEWTON BIGELOW, M.D., AND CONSTANCE BARWISE, M.D.

Confirmation that phenothiazines, di-phenyl derivatives, and certain other categories of drugs have phrenopraxic** effects, has been established by experience accumulated in the years since the first pioneer drugs appeared. It is logical, therefore, to attempt to select from such drugs those which have the higher therapeutic efficacy and which have fewer and milder undesirable side-effects. In spite of many suggestive findings, evaluation of the action of the drugs in animals does not provide data from which human response may be extrapolated. It is necessary, therefore, to define the pharmacology of new compounds by their administration to human beings, and specifically, to patients, since it has also been abundantly demonstrated that the effects of phrenopraxic drugs on healthy individuals are different from their activity in patients with mental illness. Such a testing technique must needs have a high reliability, be susceptible to widespread use, and be capable of providing reproducible results. Such results should also be visible within a relatively short time.

The present paper describes a rapid screening technique of high reliability used at Marcy (N.Y.) State Hospital. It provides a rough but useful picture of the pharmacology of a drug in a period of three months, in contrast to the usual period of eight months or more.

This rapid screening technique depends on two principal points: one, the establishment of rigidly-defined and unalterable diagnostic categories; and two, the use of the Marcy Evaluation Scale.

The symptomatology and intrinsic characteristics of mental illnesses are sufficiently diffuse as to permit the existence of the most variegated symptoms within any one of the extant so-called "diagnostic categories." For the present purpose, each test group category has been defined in such ways that a patient must present a specific type of symptoms, and have a specific evolution of his illness in order to belong to any particular category. In brief, these categories consist of the following:

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**"Phrenopraxic": having action on the mind, understood to be beneficial.

Diagnostic Categories

Schizophrenia, recent

The onset of schizophrenia, recent, must have been acute and well identified; and not more than three years may have elapsed since the onset for inclusion in this group. Patients must show dereistic or delusional thinking, and affect must be either rigid, fixed or flat. A division into sub-categories may be made if the patients show clear-cut signs of one of them, as described in the following.

Schizophrenia, chronic

The onset of schizophrenia, chronic, may have been insidious or acute, but must have occurred more than three years before the test situation. The symptomatology must have been fairly similar for two consecutive years (no cyclic recurrences). Thinking must be delusional, the affect flat or inappropriate, the psychomotor sphere altered, and a break with reality—even if partial or segmented—must exist.

Paranoid

Paranoid patients must show delusions, and affect must be rigid flat or inappropriate. The attitude of the patient should be one of preoccupation with the outside and outside influences.

Catatonic

Delusional thinking, rigidity and flatness of affect, with prominent autism, characterize the catatonic patient. There is an attitude of self-preoccupation. Afferent mental mechanisms are impaired, resulting in bizarre psychomotor manifestations (such as grimacing and posturing), which must be clearly identifiable.

Simple

Dereistic thinking, flatness of affect, indifference, passivity and apathy must be present in simple schizophrenia. Delusional thinking should not be too prominent; and hallucinations, if any, should be very rare, appearing only sporadically. The intellectual output is very poor.

Hebephrenic

Thinking is delusional in hebephrenic schizophrenia; the affect is very inappropriate and fluctuating. Unmotivated activity with little, if any, empathy toward the environment must be noticeable. Hallucinations and, in particular, response to hallucinations, must be detectable. The intellectual capacity is poor and markedly deteriorated.

Affective Psychoses

Patients in the affective psychosis category must have histories of previous episodes for at least a year before the observation for diagnosis.

Manic type

Psychomotor overactivity with over-talkativeness and pressure of speech must be present in the manic type. Thinking is increased in quantity but rather impaired in quality. Affects may fluctuate, and emotional displays are immoderate. Illusions, misinterpretations and hallucinations may be present, but not delusions. Psychomotor activity is always related to the thought content expressed.

Depressive type

Mental productivity in the depressive type is scanty, illogical, morbid, and directed against the self. The affects display intensity and a well-identifiable type of morbid sadness. Patients show psychomotor retardation and paucity of movements.

Endogenous Depressions

Patients in the endogenous depression group should have been ill for over six months and may be either neurotics or psychotics —the difference being established by breaks with reality caused by the psychotic process, and the absence of such breaks in neuroses. Two types are recognized.

Overt Depressions

Thinking is conventional and logical in overt depressions, except where it relates to the marked sadness and feelings of hopelessness which form the affective tone. The display of affect must be easily noticed. The patient's attitude is one of self-preoccupation, with prominent grief. Somatic complaints are few and vague, but psychomotor activity is noticeably disturbed.

Larval Depressions

In larval depressions, the manifestations of grief, hopelessness and sadness are not expressed directly. On the contrary, in this group of patients, one finds a different expression for these feelings. Patients are irritable, have poor concentration, poor capacity for sustained effort; they have markedly bothersome dysphoric feelings, poor appetite and insomnia.

Senile Psychoses

Senile psychotic patients must be over 70 years old and have no clinically detectable hypertension or arteriosclerosis. They must

have shown for at least a year partial disorientation and confusion, recent memory defects and a definite, even if partial, break with reality, of gradual onset.

Arteriosclerotic Psychoses

Arteriosclerotic psychotic patients must be over 60 and must show clinical evidences of arteriosclerosis in the physical field. The symptomatology otherwise resembles that of senile psychosis, and must be shown for the same duration.

Psychoneuroses

Psychoneurotics must show good reality contact, awareness of dysphoria, but no control over their manifestations. The onset must have been insidious over more than two years.

Anxiety Neuroses

Patients classified in the anxiety neuroses must show a definite amount of anxiety, which should not have a definite place of implantation but be, on the whole, rather free-floating. Palpitations, intense sweating, and other psychophysiological manifestations of anxiety need not be present. On the other hand, it must be established that the anxiety is not due to a real, as opposed to an unconscious, threat to the patient.

Conversion Neuroses

Conversion neurosis patients must have little if any obvious anxiety. However, they must show a clearly observable conversion (such as anosmia or aphonia), and such conversion symptoms must be recorded.

Obsessive-Compulsive Neuroses

In obsessive-complusive patients, it must be possible to elicit anxiety by simple questioning in relation to obsessions. Patients in this category must adjust their behavior patterns to their obsessions and compulsions, the character of which must be recorded. The affect must be rigid but not inappropriate.

* * *

The symptoms included in the definitions of the foregoing groups were selected as those most common and representative of each category. They are used only to "set" the category, and have no evaluational function.

Patients who do not meet the established requirements are simply not used for screening purposes. The intent of establishing these rigidly-defined groups is not to make "better" diagnostic categories but to permit the best available comparison among

different types of patients. The more comparate the history, evolution and symptomatology of each category, the more comparate the results. The terms used in the definitions, such as dereism and autism, are themselves rigidly defined for the sake of standardization and reproducibility of meaning.

It has been the experience at Marcy that when patients are grouped in the manner described, the reactions and responses to drugs of patients in a given group show a great similarity. It is, therefore, possible to use smaller groups of patients to test and evaluate the results of a particular drug; and it is also possible to compare the actions of drugs of different types on any given category of patients.

Before giving specific illustrations of the technique, the Marcy Evaluation Scale is presented in outline as a guide to interpretation of the curves shown in the figures to follow.

Levels of Marcy Evaluation Scale*

5 A—This represents the condition of maximum mental affliction. Maximum signs are present, and the patient has no sphincter control and is incapable of helping himself in any way.

B—This is a state of maximum mental disturbances. The patient has partial or total sphincter control and is partially able to help himself.

4 A—The patient is in limited contact with his environment, has full sphincter control and can help himself in usual endeavers with aid and supervision.

B—The patient remains in only partial contact; he shows primary and secondary mental symptoms but is able to help himself without supervision.

3 A—The patient is largely in contact, shows primary mental syndromes but only occasional secondary ones. He is able to help himself and others and may be able to perform minor tasks under supervision.

B—The patient is in full contact, shows primary but few secondary signs, can help himself and others without supervision, and can perform tasks around the ward.

2 A—The patient is in contact, shows only primary signs, is beginning to show motivation, is sufficient unto himself in the ward, and may participate in group activities out of his ward.

B—The patient is in good contact, shows minimal psychiatric signs, is able to perform without supervision and can largely have the

*Brief description of the conditions of patients in the various levels.

run of the grounds. In both 2 A and 2 B, the patient is capable of going home for short visits.

A—Minimal or no psychiatric signs are detectable. The patient may remain home with minimal or no supervision but is capable of only
1 limited effort. This is a stage of partial remission.

B—Full remission. The patient is capable of employment and sustained effort. No detectable psychiatric symptomatology.

The possibility of comparing two drugs is most important in the present rapid screening technique. From prior studies, using an early form of the Marcy Evaluation Scale, it has been possible to prepare curves representative of the therapeutic efficacy of such drugs as chlorpromazine and reserpine, on the different categories of patients. These curves reveal the amplitude of therapeutic efficacy as plotted against the time it took to produce the improvement, as effected by a therapeutic dose of the drug. Changes involving from 50 to 75 per cent in amplitude in these curves may be seen in general in the space of three months. (See Figure 1.) By

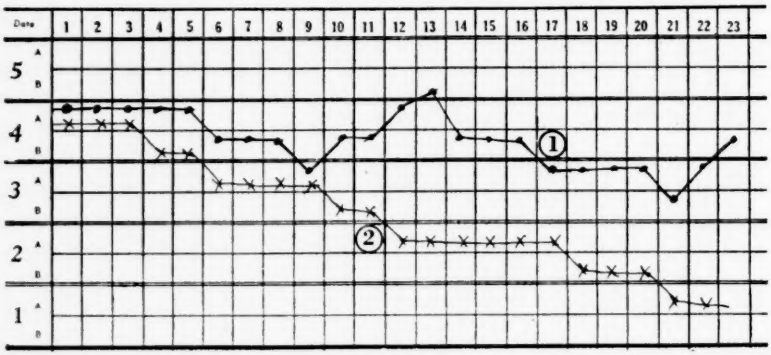

Figure 1. Upper curve (1) is typical of the course of an untreated chronic paranoid schizophrenic. The lower curve (2) shows results of treatment with chlorpromazine at therapeutic doses. The advantages of chlorpromazine treatment are reliably evident by the twelfth week.

plotting a similar curve for a new drug, one may compare it with the curve produced by, say, chlorpromazine, in the same categories of patients. It becomes relatively easy then to determine how the two curves compare in amplitudes and speeds of action for therapeutic doses. This allows a rapid determination of whether a drug is equal to, or better or worse than, the drug used as a standard. (See figure 2.) Families of curves may be obtained,

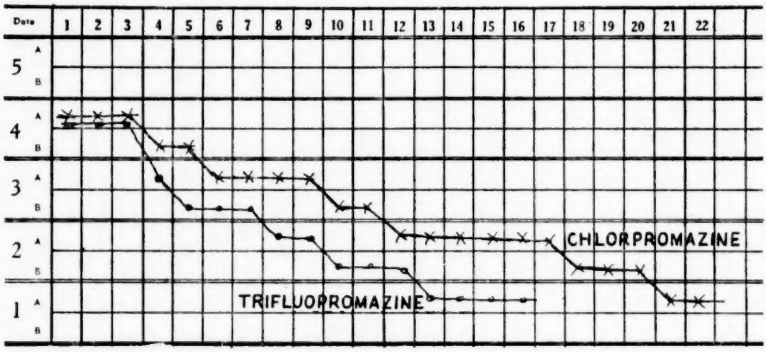

Figure 2. Curves obtained by treating chronic paranoid schizophrenics with chlorpromazine (upper curve) and trifluopromazine (lower curve). The more effective action of this last drug can be seen clearly by the fifth week.

corresponding to different dosages, by which means the minimum effective and maximum useful doses can be determined.

The full Marcy Evaluation Scale, a complete description of which will be published in another paper, consists of 72 indices relating to six categories of manifestations or functions which can be objectively elicited by observing and interviewing patients. Each of these indices is also strictly defined for semantic and communication purposes. This scale is not so complex and does not require such highly trained personnel as the Malamud scale,[1] nor it is a simple behavioral assay to be performed by average psychiatric aides, such as Lucero's scale.[2] It requires trained personnel, in the Marcy case psychiatrists and specially trained research nurses. Each index carries a specific rank, and these ranks serve to place the patient in one of the five levels, which have been briefly described in the table. The patient's level is inscribed every week in a special chart, and by connecting these positions together, a curve is obtained. (See Figure 3.)

This rapid screening procedure crystallized 18 months ago from numerous experiences and studies, in part reported previously.[3] It was put to the test by selecting two new drugs about which minimal "human" information was available. The pharmacological properties of these drugs, as spelled out by the three-month rapid screening method involving 60 patients, closely correlated with the results obtained after a prolonged and intensive subsequent study involving more than 200 patients.

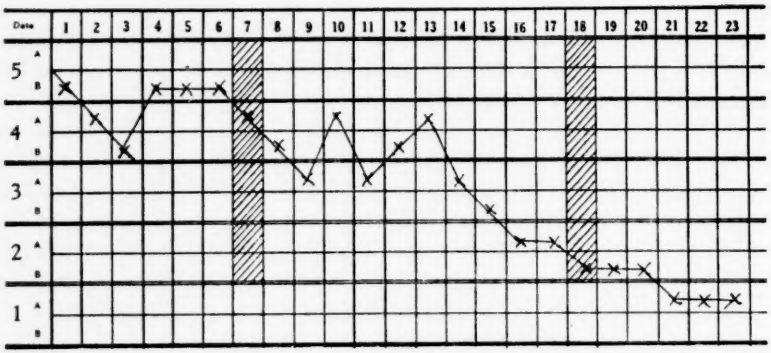

Figure 3. Typical curve showing treatment of a chronic catatonic schizophrenic with phenyltoloxamine. Medication was started the seventh hospital week. Results were evident by the eighteenth week. Levels 5 to 1 comprise scale chart. The lower columns are identified in bold letters to make them readable.

Medication used
Dosage
Frequency
Route
Side-effects (code).
Complications (code).

In the writers' hands, this system permits the economical screening of new compounds. Inactive or toxic ones are weeded out, and useful ones are investigated to the full extent of their parameters, permitting more sophisticated and accurate employment of their therapeutic properties. Should other investigators employ this method, the results of all such studies should be highly comparable, and many present-day discrepancies, evident in so many clinical reports, would ultimately disappear.

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SOME CLINICAL NOTES ON THE SIGNIFICANCE OF THE NUMBER FOUR*

BY BERTRAM P. KARON, Ph.D.

The importance of the number four within the framework of Jungian theory is well-known[1-4] (and see, in particular, *Mysterium Coniunctionis*[5, pp. 164-321]). Jung points to the quaternity of the four mental functions (the two pairs of opposite functions: thinking vs. feeling, and sensation vs. intuition) which play such a central role in his theories. He also documents in detail the attractiveness and power attributed in many different cultures and periods to the manifestations of this archetype. Such manifestations are: the number four itself, the quaternio, the square, the circle divided into four parts, and the four-armed cross (for example, the Christian cross). According to Jung, this is an archetype of almost unequalled potency, importance, and interest, and, like all archetypes, it is put forth by Jung as evidence of the racial unconscious, inasmuch as it is postulated to exist in all cultures.

An alternative view with respect to universal symbolism, and one to which the present author subscribes, is that certain human problems are universal because of the biological nature and common experience of human beings. Where there are simple and readily available objects and ideas which are peculiarly apt for the expression of certain emotional themes, and where these objects and ideas are widespread over the earth's surface, their use as symbols of these emotional themes will be similarly widespread. For example, snakes (or ideas of snakes) are to be found in almost all parts of the world. Snakes are somewhat penis-shaped, capable of rigidity and extensibility, alive (that is, outside the control of the ego), and dangerous. Is it then surprising to find that an uneducated village girl in India employs the snake in her dreams as an unmistakable penis symbol,[6] just as surely as any neurotic in western society?[7] (See also French's excellent discussion of water symbolism.[8])

This view of universal symbolism, which obviates the necessity for postulating a "racial unconscious," follows directly from Ferenczi's description of the ontogenetic development of symbolism.[9] Although such a view is not identical with Freud's origi-

*From the Department of Psychology, Princeton University, Princeton, N. J.

nal formulations,[10] it is compatible with the symbolic interpretations he presented. These interpretations, while more mundane and restricted to the psychosexual sphere than those of Jung, have also proved more capable of experimental verification.[11-12] Of course, despite generally found symbolic meanings, certainty as to the meaning which any particular individual attaches to a symbol can be attained only by an intensive study of that individual.

In Freud's view of symbolism, the symbol serves a specific disguise function.[10, p. 164] Its function is not only to express the unconscious, but at the same time to preserve the meaning of what is being expressed from reaching consciousness. It is this dual function which accounts for the use of the symbol. This disguise-function has been disputed not only by the Jungians, but by others who see the symbol as simply a primitive language without any disguise-function necessarily involved, for example, Fromm[13] and Hall.[14-15, pp. 90-100] However, the Freudian position once more seems to have experimental verification.[16] Rosen, in developing "direct analysis," a psychoanalytic therapy of psychosis,[17, pp. 3-4] extended this insight of Freud's to the symbols of the psychotic. As part of the direct analytic technique, direct interpretations are made of unconscious content, to undo the disguise-function of the psychotic delusions. A correct interpretation renders the patient's previous psychotic resolution ineffective, and makes possible a healthier resolution with the help of the therapist. Therefore, a knowledge of symbolism is a valuable tool for the direct analytic therapist.

The number three, according to Freud, is "in a class by itself" as a penis symbol.[18, p. 146] It takes on this commonly found significance from the universal biological fact that the male genitalia has three parts. But what of the number four? Freud presents no interpretation for this symbol and there seemed to be no obvious referent to the present author other than those suggested by Jung.

In Jacobi's lectures on number symbolism at the Jung Institute,[19] odd numbers were described as masculine, and even as feminine. Three was described as the first "real number." Its meanings include such diverse referents as "the child," masculinity, and activity. Four was described as "three plus one," the quaternity which in turn is the "root and source of changing nature."

Jung himself describes the meanings of the quaternity as com-

pletion, wholeness, the totality of the four mental functions, and "the container and organizer of all opposites . . . the possibility of order in wholeness."[4, p. 317] It may represent a totality with the four elements unintegrated within it, or it may represent integrated totality, unity, integration, and the self. Along with the closely related symbol of the circle, it is the "hallmark of the individuation process,"[4, p. 321] that process which is the aim, according to Jung, not only of psychotherapy but of all mental life; and the archetype of the quaternity refers both to the past and the future. Such a meaning would account for its compellingness as a symbol. Jung is unequivocal about the fact that this meaning is not dependent on experience but is inherited as part of the racial unconscious: ". . . for the latter [the quaternity] is not a human invention at all but a fact which existed long before consciousness. . . "[4, p. 227]

It was, therefore, with great interest that the author noticed that the number four played a large part in the systematic delusions of a paranoid schizophrenic under direct psychoanalytic therapy.[17] The patient considered himself God, the "infinity being." He was arranging the world so that "everything be best." ("Best," it turned out, meant breast. "The mystics told me about the connection," he said, "many years ago, but I don't think about such things any more.")

The patient divided mankind into four parts: "the poor and bad" and "the good and best"; the same four-part division was applied to inanimate objects and to ideas. He made it clear that he wanted to deal only with the last two and have nothing to do with the first two of these subdivisions. He never differentiated the poor from the bad or the good from the best; nevertheless, he resisted the idea that there were only two subdivisions and insisted on four.

There were four sexes: male, female, male-female, and female-male. Each of these could be subdivided into four more subsexes labeled the same as the major sexes. In fact each of these 16 could again be subdivided into four more, again with the same labels, making 64 "if you want to be technical." There were also four dimensions: space, time, space-time, and time-space.

There were also four divisions of the world: mankind, animal, vegetable, and mineral. There were four ways men could be inspired to do good things: for themselves, for all people, for the

world (including animal, vegetable, and mineral) and for him (God).

There were four earthly punishments he (God) could inflict on men: pain, suffering, obstruction, and social limitation; plus four degrees of damnation: eternal damned, accursed damned, worse damned, and temporary damned. There were four times: infinity past, infinity present, infinity future, and infinity eternal. There were four activities: thinking, believing, knowing, doing. In fact, the patient would insist that anything could, and should, be looked at from the standpoint of the four dimensions. Two phrases which recurred in his delusional monologues (in which he was "making the world best") were "four ways infinity from every present point in time" and "four ways infinity best."

The four activities (thinking, believing, knowing, doing) did indeed sound very Jungian; perhaps one should give the patient credit for tapping the collective unconscious instead of seeking a concealed psychodynamic problem. Thinking and believing might very well be the patient's equivalent of Jung's thinking and feeling. Similarly, knowing might be the equivalent of intuition. But doing hardly seems the equivalent of Jung's sensation, so Jung was abandoned as a source of enlightenment in favor of the patient himself.

The patient explained that, as God, he was also, of course, the greatest of philosophers. All of modern philosophic thinking would be impossible without his great discovery, which was none other than the "fourth dimension" (by this, he meant a fourth dimension to everything). You cannot, he would say, really think about anything unless you think in four dimensions. In three dimensions you can't find anything. People who "think in threes" are lost; they cannot do anything.

"If I say anything three times, it comes out all rotten. If I add a fourth, it comes out best." One day he was talking about childhood games, and devised a compulsive ritual which he explained as, "Step three times, then turn it into four."

One day he gave the author a lecture on numerology. When he was asked what the number four meant, he replied, "That's difficult. A square. A way of action. Perfect. Saturn number. Heavy —holding down. Perfect is turning threes into fours."

In this last sentence, the mystery was solved: "Four" meant simply "not three." But why not two or five rather than four?

In the patient's "lecture" on numerology, two was described only as "a feminine number," representing the breasts, and apparently the dangerous aspect of them. (After having reacted with fear to the approach of a woman with a well-endowed bosom, he explained his reaction as, "She came near me with her breast and I had a pain in my side; she was ruining me.")

The number one was also inacceptable, since it symbolized the same thing for the patient that three did. Five, on the other hand, was described cryptically as simply an "activity number"; it was perfectly acceptable. An alternative expression, and one apparently synonymous with "four ways infinity best" is "four, five infinity best." The patient got upset if four was changed to a lower number; he did not object to its being changed to a five. His reactions to other numbers depended on the special significance of the particular number: He, himself, never used anything but threes, fours—including 16 (four times four), 64 (four times four times four), and 256 (four to the fourth power)—and fives in his delusions. The lower numbers (one and two) are also avoided because someone might add something to change them into threes; four is the least number for which this cannot be done (and with abstract ideas no one can take away an element). Further, the patient can easily change any three into a four by the addition of another element, as when he added to the three more obvious times —infinity past, infinity present and infinity future—a fourth, infinity eternal.

There remain only two more steps in establishing the thesis that the number four represented the denial of the penis (and of sexuality in general) for this patient: first, to show that three is for him a penis symbol, and, second, to relate the denial of the penis (and of sexuality in general) to his pathology.

In his "lecture" on numerology, his explanation of the number three was: "Success. Jupiter [it developed that Jupiter was the god, not the planet] has threes." Jupiter, it became clear from the rest of his material, represented the patient's father. Whenever Jupiter appeared in hallucinations, he appeared as three gods —either as three Jupiters, or as one Jupiter accompanied by two lesser gods. The clinching evidence for the significance of the number three for this case came one day when the patient was sitting contemplating three pencils which he held in one hand.

The writer took the middle one, and the patient yelled in distress, "Give me back my penis."

As to whether this denial of masculinity makes sense, the patient hid his penis with his hand when talking to people. In the middle of a fairly friendly conversation when he was responding freely, the writer asked him what the number four meant, why everything had to come in fours. He immediately stopped talking and put his hand over his penis. He would make no further response to the question.

Hiding the penis represented both an attempt to hide the existence of the penis and to protect it from castration (of which he was afraid, partly because of his own desire for castration).

He referred to himself as a middle-aged woman, or woman-man. He said he was not a homosexual, but a Lesbian. He then said that all sex was bad, it was not "best," he would not have anything to do with it. When urinating, he squatted like a woman rather than urinate standing. During one visit from his mother, the first thing he said was "Gloria Vanderbilt [a mother symbol] is stabbing me in the back," accompanying the statement with a wiping motion from his anus. After she left, he said he was a Lesbian. When the interpretation was offered to him that he thought his mother would love him if he were a woman, he replied that his mother was perfect, but that she liked young girls like Gloria Vanderbilt. Another time he brought up his mother's preference for young girls and was asked whether she was a Lesbian. "No," he said, "she's a different kind of thing. She's a homosexual and I'm a Lesbian."

"Are you a Lesbian?"

"No," he said.

"Why?"

"You'll get mad."

"Why?"

"I'm going to learn, Greer Garson will teach me. Greer Garson and me will be Lesbians. We will go and get some young girls together. Greer Garson has a penis which she hides."

"Do you have a penis?"

"No . . . I mean, yes."

The question was repeated a couple of times, and each time he first said, "No," hesitated, and then said, "Yes."

When talking to his mother he generally referred to himself as

a woman and to her as a man. Still, he could not accept his desire to be a woman for fear of the castration involved—although he wished for it. He was terrified and wished to escape to a realm where there were no penes (and hence no sexuality). He was afraid of being touched by either sex. Interestingly enough, whenever Hera—who represented his mother—occurred in his hallucinations there were always four Heras—four goddesses.

In brief, he felt that his mother resented his being a man, that this accounted for her hostility. Denying that he had a penis ("turning threes into fours") was one of his persistent symptomatic attempts to gain what he felt he lacked—the unconditional, unreserved love of his mother as symbolized by the good breast ("makes the world best").*

Patients are always capable of teaching us what we wish to know about the unconscious, if only we are willing to listen. The problems which this patient symbolized by the number four are certainly common enough to suggest what the significance of this symbol may be for other humans, normal and pathological. In conclusion, the question may be raised whether it is a coincidence that the theory of Carl Jung, which originated in the denial of the importance which Freud ascribed to sexuality,[20, pp. 19-44, 67-95] should take as its cornerstone the symbol four.

ACKNOWLEDGMENT

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*The significance of the number four was derived entirely from the consistency of the observations; the meaning adduced for this symbol was not presented to the patient until after the paper was complete. Nevertheless, from the standpoint of "direct analysis,"[17, pp. 3-4] the best evidence for the correctness of an interpretation presented to a psychotic patient is a marked change in the pathology. It is worth while noting, therefore, that this interpretation, unlike others which had been offered to the patient, did, in fact, have a marked effect: The number four, with which the patient had been concerned continuously for years, disappeared from his delusional system when it was interpreted as a denial of his penis and of sexuality in general.

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CHANGES IN WEIGHT IN PATIENTS RECEIVING A "TRANQUILIZING" DRUG*

BY K. PLANANSKY, M.D., Ph.D.

It has been a common observation that patients with endogenous psychoses often undergo marked weight swings, which may parallel their psychological states, and at other times may remain unexplained. A consistent gain in weight has been noted in patients receiving physical treatments that are aimed at bringing about remission or alleviation of psychotic symptoms. Thus increase of weight, often considerable, has been reported with such diverse treatments as insulin shock, cardiazol, and electric convulsive therapy.[1-7] This increase has been interpreted at times in terms of the specificity of the respective treatment.

Similarly, weight increases have been observed in patients receiving "tranquilizing" drugs,[8, 9] although precise data are not available. Fatty infiltration of the liver has been found in subjects treated with chlorpromazine,[8] probably a sign of obesity rather than that of specific liver damage. In the writer's experience with chlorpromazine, occasional cases of a rapidly developed obesity were encountered, showing an unusual pattern of adipose tissue distribution (round faces and necks of a "buffalo" appearance). However, in view of the number of patients treated, the main problem in clinical management has been the common type of obesity.

To review the nature of the weight changes, patients' records were examined. Monthly weights are routinely taken for all patients at the Canandaigua (N.Y.) Veterans Administration Hospital. Data were also available, in patients' records, concerning behavioral changes. It is the regular duty of the ward nurse to make gross behavioral ratings of all patients, in terms of specific improvement or deterioration on the ward. The ratings are done without the participation of the ward physician.

The records of a group of 123 chronic schizophrenic patients, out of a current population of 320 patients, distributed on four wards, were studied. Monthly weights were available for 73 of the 123 patients for the year preceding the start of chlorpromazine medication. During the pre-treatment year, none of the 73 had

*From the Veterans Administration Hospital, Canandaigua, N. Y.

Changes in Absolute Weights in the Control Period and on Treatment

Before Treatment	Month	—12	—11	—10	—9	—8	—7	—6	—5	—4	—3	—2	—1
	N	73	73	73	73	73	73	73	73	73	73	73	73
	Median	137.9	138.1	138.3	137.9	138.3	140.1	138.0	139.0	138.6	140.8	140.2	140.8
On Treatment	Month	1	2	3	4	5	6	7	8	9	10	11	12
	N	73	73	73	72	72	70	65	62	59	55	48	43
	Median	139.5	142.3	144.9	147.6	149.8	151.9	152.0	150.5	153.7	154.1	154.3	156.9

a major physical illness, or had any other tranquilizing drug, or underwent convulsive therapy. Patients with a history of prefrontal lobotomy were not included in the sample.

A consistent increase in average weight occurred with the introduction of chlorpromazine medication, as seen in the table. (The weights of the remaining 50 patients, for whom the weight data were not available through the whole of the control period showed a similar increase on medication.) In contrast, no appreciable change occurred during the 12-month period preceding treatment. Further, the administration of the drug introduced into the sample a greater variability than was observed in the pre-treatment period. Loss of weight had probably been a primary contributor to the pre-treatment variability, since weight loss was one of the reasons for using chlorpromazine. In the main, variability during treatment gradually increased because some patients' weights remained nearly static or even decreased, whereas others' weights increased at different individual rates. For instance, it has been observed that a number of patients reached a new weight plateau where they then remained for some time.

One of the possible sources of variability which was investigated concerned gain in weight as a function of initial (absolute) weight. The 73 patients were divided into above-the-median and below-the-median groups on the basis of their absolute weights at the outset of treatment. The heavier group consisted of 37 patients with a median of 150.2 lbs. In the lighter group, there were 36, with a median of 125.5 lbs. The heavier group showed a consistently lower monthly increase than the lighter group. For instance, in the sixth month on treatment (with 35 patients in each group) the cumulative median gain in the heavier group was 11.3 lbs., whereas the corresponding value in the lighter group was 15.2. A similarly consistent difference was seen when the weights were expressed as percentages of the weight taken at the outset of treatment. In the sixth month, the mean was 107.6 per cent of the original weight for the above-the-median group, and 112.1 per cent for the below-the-median group.

This differential trend may be related to the degree of obesity in the period immediately preceding the treatment. Heavier men, on the average, are relatively fatter than lighter men, as has been shown, for instance, by positive correlation between the thickness of the subcutaneous fat at various sites, and the body weight.[10]

Thus, relative fatness at the onset of a new fattening period would seem to be one of the variables influencing further weight change.

The behavioral changes occurring during the treatment were, on the whole, of the type and degree that have been described in current clinical reports. Decided amelioration of symptoms was noted, especially in patients who were believed to suffer from anxiety, tenseness and fear. Significant, although clinically less clear, changes occurred mainly in the behavior of many patients who would be described as quietly regressed, withdrawn, disinterested. With the aim of facilitating an evaluation of the relationship between weight change and behavioral change, the following classification was employed: marked improvement, minimal improvement, and no change by comparison with pre-treatment behavior. Patients of the whole group were classified, and the fifth month under treatment was selected for the examination. The weight of each of the 123 patients was expressed as a percentage of the weight taken at the outset of treatment. The means of percentage weight were 113.76 for patients with marked improvement, 111.13 for patients with minimal improvement, and 105.85 for those in whose behavior no change was noted. Analysis of variance showed significant differences among the three groups ($F=7.97$, $P<.001$). The t's of 3.92 and 2.78, respectively, indicate that patients who showed marked or minimal improvement gained significantly more weight than patients whose behavior was unchanged ($P=.01$).

As to the pertinent aspects of the regimen under which the population studied has been living, it should be noted that the patients could avail themselves of a practically unlimited amount of calories before, as well as during, the treatment. The average daily ration is an equivalent of 3,000 calories (without second helpings). However, second helpings are unlimited, as are bread, sugar, butter and cream. In addition, patients can purchase coffee, soft drinks, snacks, pastries and candies in the canteen; and they fairly regularly receive caloric treats from various voluntary organizations. It has been an essential part of the therapeutic plan not to introduce any restrictive changes with medication. Consequently, the caloric intake could not be controlled. Fairly satisfactory, but by no means precise, information on changes in caloric intake has been obtained through a close observation of changes in patients' eating habits.

All patients who had been feeding problems began to eat either

spontaneously or with encouragement. Many of those who had been eating adequately before medication, started to ask for second helpings. One or two individuals became voracious. Several men said spontaneously that the drug increased their appetites. (Patients treated with cardiazol have made similar statements.[7]) On the other hand, members of the nursing staff were convinced that certain patients did not increase their food intake, although they gained weight. Such cases were investigated more closely. The results were inconclusive; the possibility of an increased food intake has never been excluded. Evidently, only gross changes in eating habits are accessible to the usual observation even when members of the ward personnel are intimately acquainted with individual patients' peculiarities. As a result of their training, nursing personnel would be more likely to detect minor deficits in patients' eating than slight increases.

Fluctuations in physical activity are even less accessible to evaluation than eating habits. It may be safely assumed that energy expenditure decreased in individuals who, for instance, ceased pacing up and down the dayrooms. It is difficult to derive an even approximate impression of changes in the energy balance in patients who become more accessible and interested with treatment, and begin to participate in therapeutic programs. It is felt that, on the whole, food intake has been a more decisive influence on weight changes than physical activity.

The writer does not venture to estimate the respective roles of environmental influences and medication in the attainment of the behavioral change. Undoubtedly, a gradual change of the climate on the wards occurred, both before and during medication. To start with, one of the main sources of group tension, the anticipation of electric convulsive treatments at regular intervals, had been removed since this treatment had been employed less often for more than a year before the first prescription of the tranquilizing drug, and, for several months before the onset of medication, it was practically discontinued. Group psychotherapy, too, had been introduced many months before medication, although a more expanded program developed during drug administration. Patients on all four wards had the benefit of planned group activities aimed at stimulation of interest (aside from the usual rehabilitation programs) before the introduction of chlorpromazine treatment. These programs were expanded during the medication period, but

were not directed selectively at patients receiving the drug. Several patients had individual psychotherapy simultaneously with medication. Sustained attention of the one-to-one relationship type was given to a limited number of mute, or apparently very dependent, individuals (receiving medication) by trainees in psychology and nursing personnel. Coincidentally, the criteria for selection of patients to have freedom of movement without supervision were broadened. Thus, it is seen that an endeavor at reducing the environmental sources of ward tension was exercised, before, as well as during, the administration of the tranquilizing drug. No sudden changes in the ward management occurred. However, patients were aware of a new treatment, especially in the initial period; and, in general, they enjoyed the nurses' attention that went with the dispensing of the drug and observation of its effects.

The following brief case histories may illustrate several types of relationship between weight and behavior changes.

Case 1

H. N., a 36-year-old man, first experienced psychotic symptoms at 27. Within a year, hospitalization was required, and he remained continuously in the hospital until his recent discharge. The initial, acute phase, characterized by confusion, seclusiveness, underproductivity, some paranoid trends and auditory hallucinations, cleared with ECT. During most of his hospital stay, the patient was indifferent and resigned. Closer exploration revealed fears which he apparently did not dare to express. Frequently, there were periods when he was tense and irritable, with episodes of assaultiveness.

His weight curve showed a persistent loss during the two years before medication. On chlorpromazine, he gained 36 lbs. within the first three months. He became friendly and pleasant, and was able to accept actively a rehabilitation program which had been outlined and explained to him. He left the hospital within five months after the beginning of medication, and, 18 months after his discharge, he was still gainfully employed and socially active in his community.

Case 2

A. R., aged 39, became psychotic at 33, and has been continuously hospitalized. No definite improvement was achieved with the usual treatments, including ECT. For a long time, A. R. would squat in a fetal position in a chair, emitting high-pitched, rapidly repeated shrieks or apparently meaningless words. During the 12 months before medication, his weight showed minimal fluctuations. At the onset of treatment, he

weighed 115 lbs.; after 12 months, 181 lbs. A reducing diet of 1,800 calories was then prescribed, and he began losing weight.

A marked behavioral change occurred during the treatment. He now moves freely about the hospital, talks properly, although not spontaneously, participates actively in group therapy, takes typing lessons, reads newspapers with understanding, and enjoys the weekly dances. During 12 months on the reducing diet, he lost 30 lbs., although he continued taking the drug (450 mg. daily). When the dose was halved, he began emitting shrieks again, but became quiet with an increased dose.

Case 3

R. N., a 52-year-old patient, developed a psychosis at the age of 24 and has been continuously hospitalized, with a diagnosis of schizophrenic reaction, hebephrenic type. He was very regressed for many years, and could not be induced to participate in any activities. All day long, he would sit in a fetal position, mumbling, and, with a bland face, methodically tearing clothes without any signs of anger. During the year before medication, he would tear to strips anything on himself, including specially made nylon suits. Soon after he had been started on chlorpromazine, he stopped tearing clothes, would leave his chair occasionally, and would listen to a simple talk, apparently with understanding, and with an occasional appropriate smile.

R. N. spontaneously started going to church services and to movies; he attends a reading group and evidently enjoys reading under guidance. At the onset of treatment, his weight was 137 lbs.; in the ninth month it was 178. He was then put on a reducing diet of 1,800 calories and immediately began losing weight. When the dose of the drug was substantially reduced, he again began to tear his clothes. After an increase he stopped and now wears clothes normally.

Case 4

J. T., 26 years old, a Negro, first experienced difficulties of adjustment at the age of 18, and broke down with symptoms of an overt psychosis at 23. He had three short hospitalizations before his most recent admission at 25. He has many persistent somatic complaints of a hypochondriacal character and often displays bizarre mannerisms. Several depressive episodes are in his history. His current diagnosis is schizophrenic reaction, paranoid type. He has a pressing homosexual problem, apparently controlled at the price of painful tension and inability to enter into relationships with men. He gained 32 lbs. within seven months on medication; however, no change has been noted in his behavior.

Since his last admission, he has remained visibly tense and uncomfortable, sensitive, shy, sad, wide-eyed, and perplexed. After a few months on the drug, a new type of bizarre, compulsive behavior disclosed that he had ideas of impurity. After discontinuation of the drug, he began losing

weight rapidly (30 lbs. within two months), again without any noticeable change in behavior.

Case 5

J. M., aged 45, had displayed severely deviant behavior since he was about 14. He was first admitted to a state hospital at 23, and had several hospitalizations before he was inducted into the Army at 31. Shortly after entering the service he developed an overt psychosis, and has been continuously hospitalized until the present time. He has been severely disorganized for a long time and has not improved in this respect on any of the usual treatments. Throughout the years, he has been described as seclusive, inaccessible, surly, with periods of assaultive behavior. During the four months before chlorpromazine medication, he lost 17 lbs. No behavioral change was noted with medication. However, the response on the weight chart was an immediate one. He began gaining steadily, and, within 14 months, his weight increased from 138 lbs. to 173.

Since there was no change in his behavior, the drug was discontinued; and, again, the response on the weight chart was immediate; within four months, he lost 22 lbs. Throughout the medication period, he continued to be inaccessible, and negligent of his personal appearance. He was sloppy, would pick up garbage, hoard rubbish on his person, and angrily avoid any personal relationships. He would still strike out if approached by personnel or another patient at a wrong moment. No gross change in his eating habits has been reported. As before medication, he still mixes pieces of paper with his food.

Discussion and Conclusions

On reviewing the meager literature on changes in weight in the course of mental illness, one finds that valid observations were made about 100 years ago. In fact, no additional data seem to have become available since that time, except for a few recent reports concerned with modern physical therapies. Nasse,[11] in 1859, reviewed the literature of his time, with an introductory statement that since Esquirol it had been a recognized axiom that healing in the "insane" began with improved nutrition. He then goes on as follows "... however, I have not found in the literature that anyone would have taken the trouble of checking the truth of this statement by taking the weights of a larger series of patients." Esquirol, in his turn, reminds the readers that it was Pinel who stated that poor nutrition aggravates and prolongs mental illness. In the chapter "*De la Folie*," of his book written in 1816, Esquirol[12] describes the clinical outcome of psychoses by lysis and crisis. He states that in the termination of psychoses—analogous to gradual

resolution found in physical illnesses—psychotic symptoms (*"le délire"*) gradually disappear as obesity increases.

According to Nasse, observations were published in 1854 and 1855 by Erlenmeyer and Schultz on weekly weight changes of patients who were treated with a method consisting (in Nasse's description) of inducing topical inflammation with protracted suppuration. (The rationale of this drastic method apparently was to obtain relief of the assumed congestion of the brain.) Increase of weight was noted in all patients who showed improvement, whereas a loss of weight was observed in patients who did not respond to treatment. Further, Nasse mentions medication with opium, administered by Albers, who weighed his patients daily, and concluded that a cure without weight increase was uncertain, and that the fluctuations in weight were concomitant with improvement and worsening, respectively, of mental state.

Nasse, himself, presented detailed data on weight changes and mental conditions of a series of 116 patients, unselected as to diagnosis, but selected as to accessibility to treatment. (He stated broadly that in incurable patients the weight remained static.) He concluded that all patients who showed definite improvement, spontaneously or on various treatments, gained weight considerably, whereas insignificant gain or unchanged weight was associated with prognostically uncertain mental changes. Furthermore, he observed that relapses were accompanied by weight loss.

These old reports are noteworthy, since one finds little to add to them in the way of clinical observations.

Fürstner,[13] in 1889, having noted that there is not always a close causal relationship between food intake, motor overactivity and the weight curve, suggested an interpretation in terms of "the energy of the cerebral process assumed to underlie psychoses": When the cerebral process is intensive, the weight curve goes downward; when the process is sluggish, the curve goes upward; and, with a cerebral process of medium intensity, as in a chronic psychosis, the weight curve runs an approximately even course.

A belief that schizophrenic individuals possess specific biological attributes apparently has led observers, around the turn of the century, to speculative explanations of spontaneous weight fluctuations. It has been either implied or suggested directly that schizophrenic individuals may be endowed with a specific type of body economy, permitting gain or loss of weight without corres-

ponding changes in food intake, although—to paraphrase Nasse's pointed remark—nobody has taken the trouble to check the caloric intake of a large series of patients. Rosenfeld,[14] who attempted to study metabolism in tube-fed catatonics, compared a measured caloric intake with weight changes. He interpreted sudden and conspicuous weight gains in terms of water retention. Unexplained weight loss led him to speculate that the regenerative power of the tissues at certain periods of mental illness may be so impaired that it is impossible to achieve better nutrition, even with a high caloric diet.

Kraepelin[15] acknowledged that weight loss may be caused by the suffering that brings on the illness itself—by restlessness, refusal of food and sleeplessness. However, it is clear that he believed that weight fluctuations may be just one of the expressions of a specific metabolic disturbance underlying schizophrenia. For instance, he states[16] that "the body weight falls often to a considerable degree, even to extreme emaciation, in spite of the most abundant nourishment." Similarly Bleuler[17] states: "The weight of the body shows large and unaccountable fluctuations." He, too, saw a specific disturbance of metabolism as a cause of a "rapid decrease of weight and strength (during catatonic states) even when sufficient nourishment is given."

The tendency to attribute the weight changes to a hypothetical physical cause, dissociated from the caloric intake, has been enhanced by the introduction of physical therapies. A mediation by the autonomic nervous system has often been invoked. For instance, Bingel[1] found that mental improvement on insulin and cardiazol shock is accompanied by a rapid weight increase, which he attributed to a change in the reactivity of the autonomic regulative centers. Häfner[4] found that the most marked weight increases were in association with full remissions in patients treated with electric shock; and he offers a somewhat involved explanation. He holds that electric shock causes a lasting shift in autonomic balance. The changed type of vegetative regulation (from a vagotonic to a sympatheticotonic predominance) effects a parallel change from a leptosomic-schizothymic to a pyknic-cyclothymic type of metabolism. Thus, patients put on weight in spite of unchanged diet. This interpretation illustrates the speculative limits of the ancient constitutional notion, postulating a state of placidity for fat individuals, and a degree of malignancy in thin ones. The

concept of autonomic mediation has been revived recently in connection with chlorpromazine treatment. Selbach and Selbach[18] have suggested that chlorpromazine inhibits the centers of vegetative regulation differentially; lowering of general metabolism and a weight increase then ensue.

Apparently the belief in an all-pervading biological abnormality of schizophrenics is the main, and perhaps the sole, support of the repeated suggestions that weight changes are dissociated from the caloric intake in spontaneous fluctuations. One has an impression that inferences were often made from inaccurate observations as to patients' food intakes. It is, of course, conceivable that certain modalities of physical treatment may transiently influence the body economy. For instance, it seems that the chlorpromazine effect can be interpreted in terms of inhibition and stimulation in the homeostatic centers.[19] Thus, a weight change could occur through several mechanisms, and independently of mental state. Certainly, the concomitant mental changes—identified here pragmatically only as behavioral improvement or absence thereof—do not represent a change in a single psychological quality. Statistical analysis has taken account only of the over-all behavioral change. The differential trend between originally light and originally heavy individuals, indicates that other variables than psychological change have also influenced the rate of the weight increase.

Experimental investigations concerning the pharmacological and physiological aspects of chlorpromazine-effect have, thus far, not offered a clear clue to explanation of weight changes. Some useful information may be coming from a non-medical area of application. According to a brief report in *The Farm Journal* (July 1957, p. 27), feeding experiments with tranquilizers in farm animals are in progress. It is stated that certain tranquilizing drugs speed weight gains and improve feed efficiency in steers and lambs, while in other farm animals the weight is not influenced.

Although circumstances of psychological order, such as worry, anxiety, anguish or depression have long been recognized as causes of weight loss, further clarification is lacking. It is the writer's feeling that, unless evidence of a definite disturbance in body economy on a psychosomatic plane is brought forth, it should be assumed that weight fluctuations are directly dependent on fluctuations in eating habits. In the writer's patients, there has been

no reason to believe that weight change was dissociated from food intake.

In the present investigation, it was observed directly that patients showing psychomotor overactivity or anxiety ate better as they became calmer. Since we do not know what type of mental changes occurred in patients in whom outward signs of anxiety had not been noted, or who had not been overactive, it can only be inferred that they, too, felt more comfortable with treatment and ate better. Schizophrenic individuals who have been inert for a long time may not be able to mobilize, from their inner resources, enough energy for more organized activities—even on a modest scale. Eating may be the easiest act of self-assertion, the first step in reconstruction, as the patient awakens to the awareness of living. On the other hand, one cannot assume that every patient who eats more with treatment, is without mental pain. It is well known that psychological discomfort is one of the causes of overeating; and, on the basis of the writer's observations, limited to behavioral rating, it is impossible to exclude the possibility that in some instances medication has induced discomfort. No further interpretations can be made in the absence of understanding the tranquilizing effect in persons who do not show a clinical degree of anxiety. Thus, the direct observations made in this study can be summed up in the following conclusion: Patients feel better and, therefore, eat better. Evidently, the data presented in the report do not allow us to judge whether this is the whole story.

Since diverse modalities of physical treatment have brought about weight increases paralleled by amelioration of mental states, the gains in weight cannot be caused by effects specific to the treatments. Alleviation of mental symptoms is the only feature observed to be common to all these therapies. Thus, the explanation of weight increase should first be sought for in the improved mental state.

That the relationship between body weight and mental state may be of a complex nature is seen in occasional paradoxical reactions, as observed, for instance, by Sargant and Slater.[20] According to their experience, obsessional personalities feel tension less when in a physically run-down state; when bodily vigor is built up, the tension becomes more acute.

It is not surprising that the patients have maintained their weight gains, since this is the usual trend in common obesity.

Esquirol's observations in this connection may be of interest. He says that patients who recover through a gradual resolution of psychosis, maintain their increased weight for a while after the disappearance of psychotic symptoms, only to revert finally to their normal weight. Such loss of excessive weight is conceivable with return to more active modes of life, but is unlikely to occur under ordinary conditions in a contemporary mental hospital. Patients who retain both the psychosis and obesity, according to Esquirol, tend to develop dementia. Similarly, according to Bleuler,[21] it has been long known that, in an acute psychosis, considerable weight gain without improvement in the mental state is prognostically bad. In Sargant's and Slater's experience with insulin treatment,[19] "If the patient regains his normal weight and physical state, and retains his mental symptoms, it is a bad sign." Evidently, weight gain does not preclude regression. As seen in the present sample, many agitated, regressed individuals become fat and quiet, while remaining regressed.

From the viewpoint of therapeutic planning, it is worth while noting that there were patients in whom no outward change in behavior was noted, and yet in whom weight increased. It may be assumed that what mental changes there may have been in such cases were not accessible to the usual ward behavior rating. Finally, it is clear that the introduction of tranquilizing treatment on a mass scale has brought an entirely new problem into the wards of mental hospitals—obesity on a mass scale.

Summary

The aim of the investigation reported in this paper was to describe the weight changes occurring in the course of tranquilizing treatment, and to evaluate concomitant behavioral changes. Monthly weights of a group of chronic schizophrenics, taken during a control period immediately preceding the onset of medication, and during the months when patients received chlorpromazine, were compared. During the medication period, average weights showed a consistent increase. A significant relationship was established between weight increase and behavioral improvement. It is concluded that, most likely, an increased food intake, subsequent to the amelioration of mental symptoms, is the main cause of the weight gain.

A brief historical review of observations and interpretations concerned with weight fluctuations in psychoses is given.

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PSYCHOTHERAPY WITH A SCHIZOPHRENIC WOMAN*

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There have been many reports in the last decade of the successful application of various psychoanalytic techniques in the resolution of schizophrenia. Reports of application of this vast new knowledge by clinical psychiatrists in the psychotherapy of the illness are not so common. The authors wish therefore to give a report of a case of the resolution of a schizophrenic attack, during psychotherapy of a modified type.

Treatment has now lasted 14 months. One of the authors (A. E.) was the therapist and the other acted as supervisor. Of particular importance in the consideration of this case is the fact that the therapist had begun to treat the patient himself without specific orders to do so, though with the support and approval of his superiors once the task was begun. Furthermore, the case was the first real psychotherapeutic task which he had undertaken.

Although there has been a remission in the schizophrenic illness, the authors do not wish to claim that the recovery was causally related to the specific form of therapy used. Nonetheless, the particular responses of the patient to various alterations of attitude of the therapist do seem to be of sufficient interest to merit attention and discussion.

Case History

The patient, Margaret, an unmarried, fresh-complexioned graying schoolteacher, 41 years old, was admitted to Southern Hospital, Govan, Glasgow, Scotland, in March 1954. Her dress was rather untidy and her hair somewhat awry. She walked with her head down, avoiding people's eyes. When talking she made wide movements of her arms, sometimes slow, sometimes jerky and, occasionally, she would pick up some small article and throw it quickly from her. At times, she would pace agitatedly about the room, speaking all the time in a high-pitched, childlike, bewildered voice.

Her flow of speech was spontaneous but with sudden stops and changes of subject. When pressed sufficiently, she answered ques-

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tions; otherwise she tended to wander away from the point. On the ward, she occasionally became excited over minor incidents, but apart from that, kept to herself, sitting by her bed most of the time with her head bent, resting on her hands.

The following is a verbatim account of a typical short interview during which she was allowed to talk without interruption:

"I have been a teacher for 16 years and I do not want to go back. I had a bout of egomania three years ago [she was unable to work in April 1952]. I thought the transport system was running for my benefit. I felt then I did not want to go back, but now I will not go back.

"I have no interest in anything. Headache—I have something literally on my mind. I feel there is something to come away—a chaos, a chaos in the middle of my head. Something has got to happen from outside—a wand—to burst it—chaos—then I will be all right. The family put pressure on me to become a teacher. I get some kind of results. The inspector said I was doing all right. Don't care what I say. Headmistress puts it on me because she thinks I'm soft. Oh, I am awful tired [head in hands, voice trails off]. Conspiracy of kindness. I am all mixed up—bewildered, nobody can explain the mystery of the Universe. I do trust Dr. C. [her general practitioner]. At first I thought I was psychoanalyzing myself and then he was psychoanalyzing me. I am I not free—I have got to look after Ann [her sister].

"I want to be free in my mind, confession helped me once. I do not like my body, part of it, the breasts. At confession I told of something I used to do—a fantasy—that I was showing myself to other people—to men. Pleasant sensation in lower part of body. No boy friends that is what is wrong with me. I want rid of my breasts. I want a phallic symbol. Phallus is the sign of strength and security. I want to be like Joe used to be. Ann has had no love. She needs a man. I want to give her love but only a man can give her love. Does that mean I want to be a man? I am not homosexual, am I? I cannot look after the class, it was split into two halves, it was perfect picture of my mind. I want the two halves put together. Things do not seem real, people are sometimes shadowy—on a suspended plane. The newspapers are talking about me. I feel I am inexplicable. Do I think I am God Almighty? Who can explain the riddle of the Universe?"

Information about Margaret's background was obtained from her sister, Elizabeth. This is given with some of the patient's comments.

The father, aged 70, is alive and well. Of him, the patient said, "Father was a bad-tempered stormy character. You associate men with what you found at home." The mother died in 1929 of chronic bronchitis at the age of 52. "I always thought I got on all right with mother, but maybe I was insincere. If she were to come back, I would love her better. Maybe she was insincere. I never told mother I was menstruating."

The patient is the youngest of six siblings. Pat, aged 52, is alive and well. He is married with a family. Dan, aged 50, is single. "He is quiet and never says anything." Joe, aged 49, suffers from schizophrenia. "Joe has had a leucotomy. I am like Joe." Ann, aged 47, also suffers from schizophrenia and at the time of the patient's admission to hospital was receiving electric shock treatment. She had also been treated three years previously. "Ann was saying strange things three years ago. She got electric treatment. She has been saying strange things again." Elizabeth, aged 43, has had a thyroidectomy. She was married in 1950. "Do you think I have a fixation on Elizabeth? Do I look upon her as a mother?" The patient—41 when she entered the hospital—had had a psychological illness in 1950 which was treated at home by rest and sedation.

The patient like all her other siblings was delivered by forceps. For a brief period she was breast-fed and then put on a bottle. She always had "fads" about her food. As a child, she was very shy and clung to her mother. She appeared to be very easily hurt and lacked self-confidence. As an adult, she remained retiring and had few friends, none of them men. At school, she did well. After the mother's death the family decided that the patient should have a teaching career, because Ann had failed in her attempts to do so. The patient, therefore went to training college and eventually received her diploma. Since then, she has worked in various schools and apparently has had no difficulty in retaining her posts.

Following a routine examination at the hospital, she was presented at a staff conference where a diagnosis of schizophrenia was established.

Course of Treatment

Treatment by intensive psychotherapy was instituted three weeks after her admission. She was seen six days a week in the therapist's interview room. Sessions, at first, lasted for one to two hours, though there was a fixed time for her to come every morning.

The clinical material falls into four distinct categories in temporal sequence; and, in presenting it, the authors have utilized these for descriptive purposes. In each of these phases there is a predominant emotional theme. It will be noted, however, that productions characteristic of other phases, emerge frequently in any given phase.

Phase I

The first phase lasted four months, by the end of which Margaret's appearance had improved much in tidiness. She no longer appeared confused when talking to other members of the staff and she no longer was upset by minor incidents. She had made friends with a number of patients in the ward, often going out with them. Although, her speech was still high-pitched and childlike in tone, the jerkiness and blocking had gone, and her air of bewilderment diminished. On the whole, she appeared content and happy.

For the first seven interviews the therapist remained inactive, listening to the patient's productions. Then he started making reassuring comments, to the effect that he was an omnipotent, omniscient, protecting, forgiving and ever-loving figure. In one interview, the therapist took upon himself the roles of mother, father or God as the patient's productions indicated, e.g.

P: What am I doing here?
Th: You are here so I can help you.
P: You will deliver me?
Th: Yes, I will deliver you.
P: Then you are my mother?
Th: I am your mother and I love you.

Here the re-birth fantasy was accepted without comment on its meaning (Rosen, 1950).

The therapist continually reassured the patient of his love and protection, giving her sweets and chocolates, often placing them in her mouth. He insisted that she sit next to him, and allowed

her to hold his hand, put her head on his shoulder or even put her arms around his neck. Toward the end of the first phase comments were made about the dynamic meaning of the patient's productions, but these were not related to the transference:

P: Why have I wanted to have my hair cut and cut?

Th: It is like having your breasts removed.

P: Yes, and like my fingers though not so much now. I wanted the skin off down to the bone, but that would have been no good.

Th: You wanted to be a boy for mother to love you.

P: I wanted to be small again, a baby to cuddle into mother. [and, dreamily she swayed toward the therapist laying her head on his shoulder].

The therapist's intuitive remarks were made on the basis of his knowledge of her history, of her previous statements, and of her daily behavior reported from the wards. At all times, he was careful not to give any appearance of rejecting her; for example, she was always allowed to leave in her own time after the therapist had indicated that time was up. Her attitude to this is shown by the following remarks: "One of these days I will clout you for telling me to go—och, but I know you will not tell me to go until I am ready."

He gave her permission to phone him at any time of the day or night if she felt the need, and he enlisted the co-operation of other members of the medical and nursing staffs in building up the appearance of his omnipotence and omniscience.

He satisfied as completely as possible the patient's dependency needs, even to the planning of her day for her.

The following is a typical excerpt from an uninterrupted flow of speech toward the end of this phase:

"My father—I wanted to destroy him. Was I a baby? A little bundle of quivering rage. I was placed in abeyance. I felt he was an intruder between mother and myself.

"When I was little I used to lie in bed and see a corridor on the wall. . . . I think I was sleeping with Elizabeth . . . but I don't think she was there all the time—it was a lovely corridor and at the end was an opening . . . something about that opening . . . Madness is not so bad as people think. You escape into a fantasy world. Only to the onlookers it looks bad."

Phase II

The start of the second phase, which lasted about five weeks, was marked by a change in technique. The therapist began to pay more attention to the transference and started making his remarks emphatically while using basic terms, reassuring the patient all the time, however, of his love and protection.

P: I want rid... I don't know.

Th: You want rid of your tits.

[There was a violent reaction. She stamped, shouted and banged on the desk.]

P: No, no. My breasts, those nasty things, those protuberences. I wish they would dissolve—or maybe I should give them to you.

Th: I want you to keep your tits.

P: No, no.

Th: [Loudly] I want you to keep them. You think I will not love you if you have them. You are wrong. I do not want you with a penis.

Time after time, in response to such comments, she became agitated, shouting, stamping, throwing articles about and punching the therapist.

As this phase progressed it was noticed that when she placed her arms around his neck she became tense and agitated, and when she leaned her head on his shoulder she was calm and relaxed. Finally the following exchange occurred:

P: Frustration—a sensation...

Th: Where?

P: Here. [pointing to her breast.] [Then confusedly:] Traveling down.

Th: You want my phallus. It is not wicked to want it.

P: Oh no. ... Yes, but you won't think it's naughty?

Th: No.

P: I do not know if I have a place for a phallus. I want—you—between—my—breasts.— I—want—you—to—lie—on—me—and—me—to—lie—on—you. ... Everyone is half and half. I want to eat you up.

A few days later, following a similar exchange, Margaret said, "What do I know of a place for a phallus." The therapist said, "It is safe to have a place for one. I shall love you and feed you just the same." "I suppose I know it, but deep inside I don't. Maybe, I think I am Joe." To which the therapist replied, "You

do not know the difference between a boy and a girl. You think your clitoris will grow into a penis and then mother will love you." At this, a strained expression came over her face as if she were trying hard to grasp some thought and express it: "A something —a something coming through—somebody—contact with reality —you—me—gone." There was much more about this time of the estrangement of her genital body image and it seemed to the therapist that just as the child has to learn as she grows up so had the patient, and just as the child is helped by the activities of the mother then so could the patient be helped by the activities of the therapist. And so he began to insist that she examine herself despite her agitated reaction, "No, no not there—can I have a sweet?"

During this phase she continued to improve symptomatically and by the end of it she had gone to the hairdresser; she had bought nylons and a new dress, and had started wearing lipstick. Feelings of unreality and ideas of reference had gone.

The therapist was actively sharing her fantasy life, and the next problem was to bring her out of her psychosis to the phase of the "neo-neurosis," utilizing this relationship. As far as the patient was concerned, the present situation could go on indefinitely. "Why can't I be a patient forever? Perhaps, I should kill you and then I would always have you."

It seemed that one way of achieving his aim could be to carry the patient on through the phases of emotional development as if she were a child, starting with weaning; and, as it appeared to him that the patient's positive relationship would be strong enough to withstand the frustrations involved in this process, he began to carry out this plan. With this, the next phase, that of weaning and of anality, was entered upon.

Phase III. *Weaning and the Anal Phase*

This third phase, which lasted 10 weeks, opened when the therapist announced to Margaret that he was going to wean her and that this was the first stage in her growing up. Accordingly the amount of physical contact was reduced by reminding her continually that she was now older. He continued feeding her for some time longer, although the amount of this too was gradually reduced. Particular attention was paid to material referring to control, anger, expulsion, retention and the giving of gifts. Ac-

cordingly, her productions were increasingly of this type, and her behavior and reactions matched them. Comments were couched wherever possible in terms of the patient's own childhood language.

P: I quarrelled with my father last night. I think I must have hated him.

Th: You are angry with me. It is all right to feel angry with me.

P: No, I do not feel angry with you. [She toyed with the ash-tray and suddenly lifted it up to throw it.]

P: I could smash this against the wall.

Th: You want to smash me. You fear your anger. I still love you. It is all right to feel angry. I will not reject you.

P: No, I do not feel angry—oh, I could crush your skull and eat it. Go on, give me a sweetie.

An important theme that recurred constantly during this phase was the patient's fear of losing control, and fear of having an irresistible impulse. For a time, she actually became constipated. The therapist was also continuing to urge her to examine herself.

P: Are you sure I can control... Pandora's box?

Th: You are afraid of your anger. You can "excrete" it. Nothing terrible will happen to you.

[She became agitated. Then...]

P: Bluebeard—To explore the unlocked chambers with him in the background to help.

Th: Who, Bluebeard?

P: No, God.

On another occasion after she had made a gesture, this followed:

Th: You are angry with me. [She leaned forward.]

P: A little rage. [She picked up and brandished the blotting pad.] Frustration.

Th: "Excrete" it. [She slapped the therapist's arm.]

Th: Go on, "excrete" it.

P: I will slap your face.

Th: "Excrete" it. You will not lose control. [She banged the desk, and unwinding her scarf from her neck she shouted:]

P: Hamlet, I could strangle you.

Th: "Excrete" it. You will not lose control. You will not be rejected. "Excrete" it.

P: No, no... [She wound the scarf round the therapist's neck and pulling on the ends she shouted:] I can tighten it.

Th: You will not lose control. "Excrete" it. It is safe. [She paused, looked intently at the therapist, then slowly unwound the scarf from around his neck. There was a silence and then clearly and deliberately she said:]

P: I feel angry because you are unattainable, because you do not need me.

It will be noted that, in the first remarks cited, there is a reference to exploring the unlocked chambers. In the therapist's view, this referred to the fact that he was continuing to urge the patient to examine herself. This she continued reluctantly to do for a number of weeks; and, during this time, a cloacal fantasy was produced: "It's a dangerous area. A nasty place, blood and water and excreta, disgusting, a sort of drain."

Another fantasy that she had was of urinating through her clitoris. At last when she was able to distinguish her anus, she declared herself unwilling to explore further. She felt there was a block there. This, the therapist, interpreted as caused by fear of excreting on him in her anger; and he reassured her at the same time that nothing harmful would happen to her. And so with his encouragement she was more and more able to examine herself, and, by the end of this phase, had found the "middle hole" as well as her clitoris, urethra and anus.

During the preceding phase (Phase II) the therapist had asked the patient to attend occupational therapy. She had agreed reluctantly: "I have no interest in making things. Perhaps for you. You tell me what to make." During the present phase however the therapist brought the giving of gifts near the center of the picture. He continually encouraged her to make articles for him, receiving them with thanks and praise; and, eventually one day, she brought him a toast-rack which she had planned and made on her own. This positive aspect of anality seems to have been the crucial factor in supporting the patient through this painful and disturbing period of her recovery.

For a time during this phase there was a mild recurrence of her feelings of unreality and of those of panic. She also became afraid that she might once again develop grandiose delusions. These symptoms passed however, and she eventually was able to verbalize her hostility to the therapist. Two months after the start of the "weaning process," she had improved sufficiently to be able to leave the hospital and to return daily as an out-patient.

"When I first came in here," she said, "I never thought of going out. I simply came to see you everyday, but now I think ahead, of going back to teaching some day."

The theme of loss of control began to disappear and although for the next month she continued to produce anal material this gradually diminished and Oedipal material increased. Once again the technique was changed. The therapist began to abandon his direct intervention, becoming more and more passive, paying particular attention to the genital material as it occurred. Once again the patient responded with more and more productions of this type. Her symptoms changed also. She became anxious and had palpitations. This occurred in agoraphobic situations and was usually related to coming for treatment; for instance, she became anxious at the bus stop on her way to a session.

Phase IV. *The "Neo-neurosis"*

The patient has been suffering only from a transference neurosis for about 10 months at the time of this writing. She was passed as fit for work by the Education Authority medical officer and was scheduled to resume work in the autumn of 1955. Now she sits at the opposite side of the table from the therapist. She began this about six weeks after her discharge from the hospital—under the influence of her fear of her transference sexual fantasies. The therapist treats her on traditional analytic psychotherapeutic lines; and, although she remains a sick woman emotionally, there has been no recurrence of her psychotic symptoms. To quote her: "When I first came I did not know that I was ill. I know that I have recovered from that illness but that I am now in a different kind of illness. You will help me until I am really well?"

During the psychotic phase, the patient responded in marked fashion to certain intuitive comments. Information which has emerged during the "neo-neurosis" seems to explain these reactions. For example, early in treatment the patient had been protesting that her dependency was ridiculous in a 40-year-old school teacher. The therapist had said that deep inside her there was a frightened "little Margaret" who needed to be nursed. The patient was calmed by this remark, and frequently afterward referred to little Margaret's happiness. During the "neo-neurotic" phase the patient stated that when she was about three years

old she was called "Little Margaret" and "Wee Maggie" in her family.

The two brief illustrative examples of psychotherapeutic exchanges given in Phase II, are more understandable in the light of the following information. She recalled being bathed by her mother; her father was in the room. She had noticed her father looking at her, and became aware for the first time that her breasts were growing. Her mother also looked down and said "Are your little diddies growing then." Her father had turned away, apparently embarrassed. The patient said she felt, when her father looked at her, that it was as if he had touched her breasts. She was frightened and ashamed and wished she were not made that way. "Why am I afraid of the breasts. You know when I talked about the split, it wasn't a mental split, but the split between the breasts. Take away the breasts and give them to someone else and I'll be smooth." Later in the same interview she emphasized that, to her, the breasts were the important symbols of femininity. The use of the word "tits" in treatment had reminded her of her mother speaking of "diddies."

More recently while speaking of the same incident, Margaret said, "I was very angry when he turned away, but that I felt appealing. I didn't want to take him away—not an exclusive relationship—just to share in theirs. Mother was mocking—the old besom—so I went back to her. But I wasn't too sure of the breasts from the start—felt guilty even before anything was said. It reminds me of the time when I had that fantasy in bed. I arched myself—showing my breasts—and said, 'Whoever you are, take me.' It felt as though something were going up and up. I was afraid that something was going to happen to me—that I had started a baby." When speaking in this way the patient recollected her fear and disgust about her breasts, saying that she remembered thinking that the only way to deal with the difficulty was not to have them.

The "block" to which Margaret had referred frequently was "an imaginary phallus." She said while discussing her sexual feelings, "There is a block. There is something within me which makes me unable to have the feelings and the thoughts. It makes me the aggressor. My thoughts are so loose I get lost in the byways. How can I get back into the mind of a little girl who gave herself an imaginary phallus."

It will be recalled that during the "anal phase" the patient had made many things for the therapist. One of these gifts was the toast-rack. Frequently, when annoyed with the therapist, she would lift it and pull off small pieces. On one occasion after the therapist had remarked that she felt dissatisfied with him for not taking it home, the patient said, "You are the dispassionate psychiatrist, I can't have you. I suppose I want to take your hand and to have those sexual sensations. I'll take that home." She pointed at the remains of the toast-rack. "I made that to show you that I was still friendly to you at that time. It was a counter to my anger."

In the discussion of Phase IV, no attempt has been made to illustrate the economic development of the "neo-neurotic" relationship which appeared to vary little from the usual one encountered with anxiety neurosis. The material reported is intended only to assist understanding of the psychosis. When it emerged it was handled by the therapist as content, and usually an interpretation of immediate transference nature was made.

Discussion

Eissler (1951) discusses the variety of methods of psychotherapy which have been successful in the treatment of schizophrenia. He comments: "Is it conceivable that all these techniques have one common denominator, namely, the use of primary processes as therapeutic tools? There is no doubt that in view of the gravity of the schizophrenic disorder, a therapist may be pessimistic and avoid intensive contact with a schizophrenic patient. But on the other hand, the gravity of the disorder, its reputation of being incurable, may act as a tremendous challenge to a therapist. May it not be that an indefinite number of therapists feel reassured in the correctness of their particular psychotherapeutic views and techniques, if they succeed in curing a schizophrenic? Can anyone doubt that at present, when so many different psychotherapeutic schools are struggling for supremacy, the schizophrenic becomes a person of particular importance to the therapist as a kind of test subject? The schizophrenic's cure promises a therapist a wreath of laurels and the reassurance that he must be on the right track."

At the institution of Margaret's treatment the therapist had been much influenced by two psychoanalytic works. These were

Direct Analysis by J. N. Rosen (1953) and the *Selected Papers* of Karl Abraham. The training which he was receiving was in a psychodynamic psychotherapy based on psychoanalysis, and his concept of the development of the mind rested on Abraham's theory of the oral, anal, urethral and genital phases. The forceful methods of Rosen seemed to him to contain the basis of a successful therapeutic approach to a patient who had suffered painful oral traumata at the hands of a "perverse mother."

Supported by the feeling that there were psychotherapeutic tools here of the greatest value, the therapist approached Margaret with the implicit offer of kindliness, understanding and help. During the first phase, the patient at once began to respond to the therapist in the way he had hoped. She accepted whatever role he adopted, and was not only reassured during interviews but began to show a good deal of symptomatic improvement. The relationship seemed to work from the start in the way Eissler suggests that a therapeutic relationship with a schizophrenic patient should develop.

With Eissler's comments in mind, a treatment program was sketched out which, it was hoped, would protect and foster the pre-verbal or primary process factors which seemed to be operating therapeutically in the relationship. The program was based upon Abraham's genetic theory, and the intention was to draw the patient from an "oral phase" into an "anal phase," and from the "anal phase" into a "genital phase." The very brief quotations in the section on the course of treatment show how the patient responded. During Phases I and II, the oral phase, she was dependent, producing fantasies of eating and being eaten; and she indicated her complete contentment in the relationship—as adequate for her needs.

Her reaction to the weaning, the entering of the anal phase, dramatically confirmed the therapist's conception of anality. His confidence in the correctness of the technique he was using supported him greatly during the early period when there were many anxiety-provoking situations, during which she was shown that her great fears of her inner badness and hostility were groundless in her relationship with him. The patient's general behavior outside the treatment situation was at all times in accord with the "phase." As mentioned during the "anal phase," she was constipated while pre-occupied with control; and she began to attend

occupational therapy to make gifts for the therapist while constructive activity was discussed. The patient has continued to produce such material and behavior responses up to the time of writing. For example the "cloacal fantasy" (which was not interpreted as a transference reference) gradually gave way to an awareness of the genitalia and finally to fantasies of intercourse with the therapist.

In discussing, as has been done here, the techniques used in this case the authors wish neither to support nor to oppose their validity, but do wish to offer a clinical example which they feel supports Eissler's statement that pre-verbal processes play an important part in the psychotherapy of schizophrenia.

Summary

The authors describe the resolution of a schizophrenic illness in a female patient aged 41 years, during psychotherapy of a modified type. The treatment followed a pre-arranged plan in which the therapist had considerable faith. The patient progressed from an oral to an anal, and finally to a genital or "neo-neurotic," phase. The authors feel that pre-verbal factors in the relationship influenced the course of the illness.

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THE SCHIZOPHRENIAS—CURRENT VIEWS: A REPORT ON SECOND INTERNATIONAL CONGRESS FOR PSYCHIATRY

BY ROBERT J. CAMPBELL, M.D.

The Second International Congress for Psychiatry was held in Zurich, Switzerland, during the week of September 1-7, 1957. The subject was "The Present Status of Our Knowledge About the Group of Schizophrenias,"* and although nothing startlingly new was presented at the various meetings, the congress afforded an unparalleled opportunity for comparison of the viewpoints and approaches of all the workers in the field. In all, over 1,900 participants were registered, and they represented 59 countries (one notable country absent was the U.S.S.R.).

Meetings were held in German, French, English, Spanish and Italian; but the main speakers, for the most part, were kind enough to repeat their papers in translation so that a single participant could keep abreast of the major contributions to the congress, no matter what his linguistic limitations. Further, the congress was well organized, and a complete program of speakers and topics was published in advance, thus enabling the participant to arrange his schedule so as to hear whatever presentations he considered important. Despite this, it must be obvious that no one participant could offer complete coverage of all the scientific meetings, which included 25 plenary sessions, six film sessions, 80 section meetings and symposia, and three tours. The present report, then, will to some extent reflect the particular interests of the author, problems of etiology and nosology, although the major presentations of all the groups participating have been included.

The sessions of the congress were devoted to relatively limited aspects of the general theme, and because few of the discussants had advance knowledge of what material would be presented in other sessions relating to the same area, there was no particular "congress-unity" in approaching the problem of schizophrenia in general. The author has tried here to organize the material presented in as orderly a fashion as possible; and, in the present report, the group of schizophrenias will be considered in the following categories: epidemiology (incidence, cultural and familial

*This title is in the terminology of Eugen Bleuler, whose son, Manfred Bleuler, was the president of this congress.

background, etc.), definition and etiology, phenomenology and nosology, course and prognosis, and treatment.

Epidemiology of the Schizophrenias

Schizophrenia occurs in every segment of the population, without regard for race, or culture, or social class. For example, Forster reports on the incidence of schizophrenia in Ghana, and his reports cover three regions with a population of five million people; Ratanakorn, from Thailand, reports on the incidence of schizophrenia in a population totaling 22 million; and Yap and Lambo report on schizophrenia in Southern China and Nigeria, respectively. All these reports are in essential agreement with Kallmann, whose statistics are reported later in this paper.

Not only does schizophrenia occur in all societies studied, but it appears, too, in all the forms generally recognized. To state this in a different way, one could say that Bleuler's fundamental symptoms are the same, no matter where schizophrenia occurs.

The content of symptoms, however, in great part seems to be determined by the culture—thus the western schizophrenic is nowadays influenced by television and radar, which he typically incorporates into his delusions, while the schizophrenic from a primitive culture complains of being influenced by the evil eye, the totem pole or the medicine man.

Lidz (U.S.A.) reports that schizophrenics in his series come almost exclusively from broken, severely disturbed or eccentric homes.*

In Thailand, schizophrenia accounts for 72 per cent of mental patients. Culture in Thailand is thought to favor the development of schizophrenia, because (a) the personality type favored by the culture is one of introversion and submission; (b) the religious training of the people, Buddhism, favors apathy, a lack of eagerness and a turning away from reality among its followers; and (c) the unusual mother-child relationship exerts regressive effects on psychosexual development. Yet the over-all incidence of schizophrenia is no higher in Thailand than elsewhere; and the

*Cf. Nielson, C. K.: Acta Psychiat. et Neurol. Scandinav., 29:281-289, 1954. (Here, a comparison of 55 schizophrenics with 100 matched healthy controls fails to demonstrate significant differences in childhood background. Factors examined included school ability, financial status, atmosphere of the home, religious atmosphere, discipline, fidelity of parents, behavior of mothers and fathers and childhood behavior of patients. See also Kallmann's findings.)

type of patient is the same: 75 per cent of all schizophrenias begin within the 15 to 25 year age range, 64 per cent of the affected patients are male, and 54 per cent are of asthenic body build. This is in general agreement with statistics reported in Western cultures, which are not felt to predispose inherently to schizophrenia.

Kallmann (U.S.A.) points out that, on the basis of his statistics, the general expectancy of schizophrenia is 1 per cent. Thus, it is not a universal potentiality, and not everyone could become a schizophrenic under certain conditions. This would cast some doubt on the wisdom of labeling schizophrenia a reaction type. It is to be noted that commonly accepted statistics give the incidence of schizophrenia in the United States as 1 in 25, which would be a general expectancy of approximately 4 per cent. Kallmann reports the following findings: (a) the majority of schizophrenic hospital patients (90 per cent) come from non-schizophrenic parents; (b) one schizophrenic parent is not enough to produce the disease in his off-spring, although one schizophrenic parent will raise the expectancy of schizophrenia in his off-spring to 16 per cent; (c) at the same time, a non-schizophrenic, adequate home is not able to prevent the development of schizophrenia in vulnerable off-spring; (d) both one-egg twins are six times more likely to develop schizophrenia than both two-egg twins, regardless of whether they are reared alone or apart.

Definition and Etiology

In 1911, Eugen Bleuler described the schizophrenias as a slowly progressive deterioration of the entire personality, which involves mainly the affective life, and expresses itself in disorders of feeling, thought and conduct, and a tendency to withdraw from reality. Bleuler noted that the schizophrenias were at times progressive, at times intermittent, and could stop or retrogress at any stage; but that they showed a tendency toward deterioration and, having once appeared, did not permit of a full *restitutio ad integrum*. Bleuler established the multidimensional nature of the schizophrenias and believed them to be organic; but at the same time, he stressed the interaction of psychogenic and physiogenic features in their psychopathology and development. Freud stressed, primarily, personality development in mental illness and the role of infantile and childhood experiences. Freud's followers have con-

tinued along this line for the most part, often to the exclusion of any consideration of the constitutional, organic background.

Bleuler's views on the relationships between the somatogenic and psychogenic factors in schizophrenia were clarified in several papers read at the congress, and were reflected in many discussions throughout the program.

Kretschmer (Germany) thinks of schizophrenia, not as an actual disease unit, but as an indispensable general conception with manifold connected syndromes. He feels that the schizophrenias occur on a sliding scale, ranging from catastrophic deterioration in puberty, with serious metabolic disturbances, to strong reactive types which are more purely psychogenic in nature. Kretschmer stresses the hereditary factor which, if present, greatly worsens the outlook. His constitutionalist doctrine supports the geneticists in their conception of the schizophrenias (see later discussion).

Hoff (Austria) points out that many workers confuse secondary results in the schizophrenias with basic causes and fail to differentiate between what causes the disease, and what factors lead to manifestations of it. He feels that the illness consists of: (a) an hereditary predisposition manifested in enzyme deficiencies, plus (b) personality factors, for the most part psychosocially determined, and (c) a specific release situation. The combination of all three factors leads to disturbed brain functioning, probably in the sphere of connection between isocortex and allocortex, and in corticothalamic associations.

Important contributions to knowledge of the etiology of the schizophrenias come from various sources. Genetic studies have given many leads, and Kallmann's statistics (U.S.A.) are particularly impressive. He summarizes his conclusions as follows. (a.) All basic behavioral components are genetically controlled. (b.) The basis of schizophrenia is probably a gene-specific, metabolic deficiency transmitted as a receptive unit-factor—that is, a receptive dihybrid inheritance. (c.) Modifying genes gives a variable clinical picture within the group of schizophrenias. (d.) The disease is manifested as a lack of ability to respond to certain environmental stimuli. (e.) The basic integrative deficiency is not yet identified, although the most likely possibilities would seem to be altered reactivity to sympathetic nervous system drugs such as mecholin, and/or failure to manufacture anti-epinephrine, and/or changes in the functional properties of copper-containing enzymes.

Studies in brain physiology and pathology have also given important leads in an understanding of the schizophrenias. Parietal syndromes, for instance, produce disorders in the body scheme very similiar to schizophrenic depersonalization. Kleist (Germany) considers schizophrenia a neurologic heredodegenerative disease analogous to Friedreich's ataxia and Huntington's chorea. He divides the schizophrenias into forms with predominantly cerebral cortex symptoms and forms with predominantly brain stem symptoms. The forms with predominant cerebral cortex symptoms are: schizophasia (speech disturbances similar to sensory aphasia), paralogic schizophrenia (paralogic thought disturbances related to agnosia); progressive somato- and auto-psychosis of paranoid type (disintegration of conception concerning corporeality and personality); catatonia with deficient impulse (lack of impulse, agrammatical speech and alogical thought disturbances, as with damage to the frontal lobe), and apathetic hebephrenia (affective graduation and retrogression of character, as with damage to the orbital brain).

The forms with predominantly brain stem symptoms are: incoherent schizophrenia (incoherent thought disturbances arising from the midbrain); paranoid phantasophrenia, progressive confabulosis, progressive hallucinosis, progressive psychosis of being influenced, progressive psychosis of reference; akinetic catatonia, parakinetic catatonia (emotional disturbances peculiar to the brain stem), negativistic catatonia, prokinetic catatonia, stereotype catatonia, iterative catatonia (disturbances in striving peculiar to the brain stem); childlike hebephrenia, depressive hebephrenia and autistic hebephrenia (midbrain symptoms).

Toxic theories have long been prevalent in regard to schizophrenia but until rather recently were considered somewhat unsophisticated. Biochemical evidence accumulated within recent years, however, indicates that there may be more than a grain of truth in these toxic theories. The indications are that faulty enzyme production results in the inadequate binding of amines, some of which are cerebrotropic, or exert their influence by reason of specific amino-sensitive cerebral areas. Both Baruk (France) and Buscaino (Italy) emphasize toxic and infectious (intestinal) causes, giving great importance to excessive or abnormal amine body production (especially diamines) due to liver or reticuloendothelial dysfunction or to gastro-intestinal diseases. (Similarly,

Vogt's "pathoklisis" emphasizes an excessive receptivity to toxic amines of particular brain areas.)

Richter (England) considers the schizophrenias to result from a defect in homeostatic adaptive mechanisms and would locate the area of difficulty in the hypothalamus. Waelsch (U.S.A.) has pointed out that one enzyme protein fraction is known to be able to fix amines; this reaction is specifically activated by calcium and is inhibited by hydroxylamine, eserine, serotonin and L.S.D. (each of which inhibits by a different mechanism). There would appear to be some analogy to the pathogenic mechanism of phenylpyruvic oligophrenia, which is a hereditary recessive disease with a disorder in phenylalanine metabolism and a destructive action on the brain.

It is wise to remember, as Richter has emphasized, that the group of schizophrenias is probably large enough to include a number of different conditions in which different metabolic processes may play a part. One could perhaps summarize the biochemical and genetic conceptions as follows:

Schizophrenia is a heredogenetic disease involving particularly the enzyme systems. This expresses itself in defects of function of individual ganglion cells of the brain, leading to disturbances of the cerebral output system, which in the normal person guarantees the intactness of the fundamental function of experience. Such a disturbance interferes with the dynamics and structure of the affected personality.

Phenomenology and Nosology

Increasing awareness that schizophrenia is really a group of disorders, rather than a single disease, makes nosology and phenomenology more and more important. It is to be remembered that Kraepelin, in outlining the symptoms, emphasizes the defects in judgment, mental activity, mental energy and emotion. Bleuler's symptoms include disturbances in associations, affect, ambivalence, autism, attention, the will, the intellect, activity, and organization as a personality. Kraepelin, then, emphasizes the thinking disorders as they are evidenced internally to the patient, while Bleuler emphasizes the objective external signs of the unknown basic disorder. Most specialists today would go along with Bleuler.

Ruemke (Holland) considers the schizophrenias primarily a disease of form, for the diagnosis can be made without knowing the

patient's thoughts, and the diagnosis can be made anywhere in the world.* Although trained in psychoanalysis, Ruemke, like many Europeans, places greater emphasis than American psychoanalysts do on phenomenology, and he tries to limit the schizophrenias on the basis of phenomenological characteristics. The European tendency is to use the term "nuclear" or "process" schizophrenia, or dementia praecox, to refer to unquestionable cases with a high tendency to deterioration and little tendency to remission or recovery. The others are called by Ruemke the pseudo-schizophrenias; by Lunn (Denmark) the schizophreniform psychoses. The nuclear types may or may not show Bleuler's accessory symptoms (delusions, hallucinations, etc.), but the fundamental symptoms are prominent. In the other types, the accessory symptoms are in the foreground, and the fundamental symptoms may not be readily apparent. As Bleuler pointed out, the accessory symptoms are not diagnostic of schizophrenia, for they occur also in many other disorders, especially in the organic group. And, as Ruemke notes, "There are many queer people outside the realm of schizophrenia."

From the point of view of diagnosis and prognostication, Lunn reports an interesting series of 250 patients diagnosed schizophrenia on admission. All patients were having their first attacks, and they were studied intensively by various disciplines—not only by clinical psychiatrists but also by a psychoanalytic group, by pharmacologists, biochemists, psychologists, and so on—who were asked to give diagnoses and prognostic evaluations on the basis of their own findings and independently of the other groups. It was found that patients tended to fall into one of two distinct groups; one, a nuclear, process group with derealization, passivity, autism, affective disturbances, concretization of associations and physical sensations with dissociation, and a second group with strong secondary symptoms, including auditory hallucinations and catatonic phenomena but no primary signs. Between these, were two intermediate groups, the episodic schizophreniform psychoses without primary autistic changes. The patients were distributed

* Cf. Berne, Eric: Am. J. Psychiat., 113:193-200, 1956. (Berne reports on visits to mental hospitals in 17 countries on five continents. He finds that the major psychoses take the same form in many regions, and that a well-trained clinician can diagnose approximately 25 per cent of the patients by inspection; and, after a few minutes of listening, even to a language he does not understand, can diagnose another 25 per cent. His difficulties in diagnosing the remainder will be similar almost anywhere.)

in these groups as follows: 29 per cent obvious nuclear schizophrenics; 15 per cent schizophrenics; 24 per cent probable nonschizophrenics; 32 per cent obvious nonschizophrenics. The highest correlations with long-term clinical follow-ups were with amphetamine provocation studies and psychoanalytic evaluation. Amytal provocation studies also correlated to a high degree but somewhat less than these other two procedures. Psychological estimates (the Rorschach, similarities tests, proverbs, word association) tended to diagnose more patients as definitely schizophrenic but included fewer of those who were really schizophrenic than were picked up by any other method.

Matte-Blanco (Chile), in an interesting paper on schizophrenic thinking, approaches associational disturbances from the point of view of symbolic logic. He finds schizophrenic thinking to be disturbed in two directions: (1) in loss of continuity of the process or theme; and (2) in structural alterations in the product—as seen in the principle of generalization, where the patient treats every individual as a member of a class or group which is itself a member of a larger class or group. Thus in response to the question "Where is London?", the patient may answer by the principle of generalization, "In the Occident." Structural alterations are also seen in the principle of symmetry, wherein all relationships are considered on a par. Thus if John is the father of Peter, then Peter is the father of John; thereby, factors of causality and time relationships are destroyed.

Hoch's (U.S.A.) concept of pseudoneurotic schizophrenia is more widely accepted by the Europeans than by the American group, although many would question the value of making this a new subgroup since it depends on the presence of fundamental symptoms which are already clearly defined. Perhaps the difference in acceptance is to be explained by the fact that the European psychiatrist is more accustomed to approach the group of schizophrenias with the fundamental symptoms in mind, and is aware of the error of depending on the presence of accessory symptoms to diagnose schizophrenia. Hoch's presentation gives a summary of the symptoms of pseudoneurotic schizophrenia:

SYMPTOMS

1. Higher level disorders of emotional regulation.
   a. Volatility.

b. Intolerance to frustration, diffuse anxiety.
c. Inability to select and regulate assertion, aggression, compliance, etc.
d. Marked sensitivity, autistic life approach.
e. A craving for stimulation and a simultaneous repudiation of stimulation.
f. A craving for protection and dependency but a repudiation of both.
g. A search for quick, magical gratification.
h. The use of intellect as a substitute for emotional reaction.
i. Anhedonia, leading to a mimicry of others and a caricature of normal behavior, with a lack of pleasurable experience and feeling tone.

2. Thinking disorders.
a. Impaired concepts, impaired abstract thinking and a tendency to
I. Disordered concept of self and body image, with formation of universalized concepts.
II. Chaotic sexuality.
III. A play acting feeling.
IV. An emphasis on ethical standards but a behavioral breeching of such standards.
V. Impaired self-esteem and confidence.
b. Ideas unrelated logically, related only through emotion.
c. Dereistic thinking.
d. Complex-bound (catathymic) thinking.
e. Pressured thoughts and thought overflow.
f. Blocking and thought deprivation.
g. Evasive, paralogical, approximate answers.
h. Lack of goal-directed thinking.
i. Indecisiveness and doubting.
j. Pseudo-philosophizing with esoteric debates about the deep questions of life.

3. Impaired volitional behavior.
a. Energy disregulation, difficulty in initiating or sustaining activity, easy fatiguability.
b. Intolerance of sustained activity toward a future goal, with performance slumps and scattered performance.

4. Proprioceptive and exteroceptive regulation impairment.
5. Impaired autonomic nervous system regulation and impaired homeostasis, particularly involving the skin, gastro-intestinal, genito-urinary, respiratory and cardiovascular systems, with exaggerated anxiety and hypochondriacal preoccupation.
6. Ambivalence.

7. Disharmonious functioning in each area.
8. Other characteristic symptoms: pan-anxiety, pan-neurosis, psychopathic symptoms, acting-out behavior and depersonalization phenomena.

In Hoch's experience about 50 per cent of such patients eventually and/or temporarily, show gross psychotic symptoms, especially following stress. Treatment of the pseudoneurotic schizophrenic is difficult because of the brittle transference relationship, and because of the danger if neurotic defenses are removed and nothing better can be offered as a substitute. Treatment includes drugs to reduce anxiety, plus psychotherapy (drugs alone fail in about half of the cases). On occasion, modified psychosurgery is indicated; this is better if performed in the precoronal plane. In selected cases, psychosurgery affords 70 per cent of good results.

Vangaard (Denmark) adds three criteria to those Hoch gives for the diagnosis of pseudoneurotic schizophrenia: (a.) The primary gain of the illness is not satisfied, for there is not enough ego strength to keep affects controlled or banished by means of the neurotic symptoms; (b.) Secondary gain (extracting libidinal gratification from the environment by means of the symptoms) is less consistently obtained than in pychoneurosis; and, when it is frustrated, withdrawal is provoked, rather than an intensification of exploitative maneuvers; (c.) Object relationships are feeble and cannot be maintained in exploitative manuevers.

Bender (U.S.A.), in a presentation of the genesis and course of childhood schizophrenia, points out that schizophrenia is the single largest diagnosis in child psychiatry. The basic controversy still is between environment and constitution. Schizophrenic children are not always grossly psychotic; spontaneous remissions are frequent, but it is questionable that a complete cure is ever obtained. Bender sees schizophrenia as a lifelong process which includes disintegration involving all the behavioral functions, leading primarily to a maturational dysfunction; and, secondarily, to biological and psychological defense mechanisms. The variables in the process of the schizophrenias are: (1) constitution; (2) severity and extent of process; (3) the reactions determined by the stage that a child is in biologically and psychologically when the disintegration begins to manifest itself; (4) the variety of defense chosen (which is determined by inherited genetic factors as well as environmental influences); and (5) the physiologic crisis,

which is always seen in the history of childhood schizophrenics and is often a precipitating factor in the onset of the psychosis. The physiologic crisis appears to depend upon embryonal plasticity and a maturational lag.

Bender agrees in essence with Kallmann's statistics (presented in the foregoing) and feels that no childhood schizophrenia can occur without the inherited genetic factor. Important in her case series, was the retention of many embryonic features in the schizophrenic child for a longer period than normal. This has raised the question of possible intra-uterine effects and a possible intra-uterine crisis. Bender notes the retention of regressive embryonic features in all behavioral areas to a far greater degree than is normal —such features often persisting throughout life. Examples are undifferentiated homeostatic functions, soft visceral and muscular tone (especially in the vasomotor and gastro-intestinal areas, thus, causing frequency of so-called psychosomatic disturbances), sleep disturbances, disturbed respiratory patterns which often give rise to speech disturbances, undifferentiated reactions to external stimuli, lack of suppression of early reflex patterns (e.g., the startle pattern), hypersensitivity to external stimuli, and primitive plasticity, so that an all-pervasive lack of pattern throughout growth and maturation results.

Bender classifies childhood schizophrenia as follows:

1. Pseudodefective schizophrenia. The patients are autistic, retarded, regressed, withdrawn, show poor object relationships, are inhibited and often mute, are physically labile, show inadequate homeostasis and poor tone and poor reactivity to stimuli, although some may be hypersensitive.
2. Pseudoneurotic schizophrenia with pan-neurosis, defects in the formation of body boundaries and the body image, difficulties in orientation and perceptual disturbances. These children often show exaggerated insight with precocious symbol formation; they tend to have high intelligence.
3. Pseudopsychopathic schizophrenia, which usually appears in late childhood or adolescense, often with a paranoid coloring leading to negativism, acting out, escape mechanisms and obsessive-compulsive features. All these suppress the fundamental schizophrenic symptoms and give a picture of psychopathy.
4. Gross psychosis.
5. Schizophrenic "living among but not with."
6. Schizophrenic type of genius and artist.

In the two-to-six-year age range, the schizophrenias seen are mostly of the autistic type, although at any point these may change into another type. Boys exceed girls throughout in the incidence of schizophrenia, although at six, there are almost as many girls —they show acute symptoms, with rapid response to treatment or a high tendency to spontaneous recovery. The latency period appears to be good for the girl but hard for the boy, who becomes disorganized, disintegrated and, just before puberty, often shows a dramatic outburst of the pseudoneurotic type. Puberty often brings remission, so that the diagnosis may be reversed. But some children, especially boys, retain their autistic and infantile outlook and often add conclusive episodes to the pre-existing symptom pattern. Still others may show exaggerated antisocial acting out without guilt at the time of adolescence and thus symptomatically show dangerous delinquency, even though they may appear to be nonpsychotic. As adults, these patients often again exhibit frank psychotic behavior.

Course and Prognosis

Diethelm (U.S.A.) presented a study of patients who were observed in or outside of hospitals for 30 years or more:

1. A considerable number of these patients first showed acute paranoid excitement (panic), with a subsiding of delusions after a period ranging from a few weeks to years, followed by a hebephrenic picture and terminating in simple deterioration. In other paranoid patients, delusions persisted several years and then became repressed. In a third group, delusions subsided but could still be demonstrated. In others, paranoid delusions remained active throughout the period of observation.
2. In the cyclic type of schizophrenia, some patients started with symptoms of depression, and schizophrenic symptoms became increasingly dominant, with progression as depressive elements subsided. Such cases usually ended in hebephrenic or simple deterioration.
3. Catatonic excitements with strong affective components of several months in duration were also seen, and these were repeated two to three times in an otherwise apparently normal and successful life.

Stengel (England) reported on obsessional symptoms in schizophrenia which he found to be rare in hospitalized patients (3.5 per cent). In Stengel's experience, approximately 15 per cent of so-called obsessionals eventually develop schizophrenic symptoms. Delusions often take the place of obsessional symptoms, but projection of obsessional impulses or ideas into the outside world is

very rare. Most patients who show such development are paranoid in type, some are hebephrenics, a few are simple schizophrenics, but there were no catatonics in Stengel's series. The group with obsessional symptoms is characterized by an absence of rapid disintegration or deterioration and by frequent remissions, especially if the obsessional symptoms precede the schizophrenic episode by many years. The rigidity and the recurrent reality testing of the obsessional may serve as a safeguard or buffer against more extensive deterioration.

Yap (Hong Kong) reported on schizophrenias in the Southern Chinese. The chronic patients are those who become ill younger, have insidious onsets so that they are referred for treatment later, show marked thought disorders, poor general affectivity, catatonic symptoms (bizarre speech, abulia, stupor), little clouding of consciousness and absent or false insight. Of no prognostic significance, are intelligence, marital status, family history, delusions, hallucinations, specific affect, catatonic excitement, precipitating causes or suicidal attempts. Only the chronic group have massive and complex bodily hallucinations.

Pacheco e Silva (Brazil) also reported on prognostic studies in the schizophrenias: The farther advanced the process, the worse the prognosis; the prognosis is better in pyknic personalities and somatotypes; the earlier in life the symptoms appear, the worse the prognosis; catatonic forms permit hope for a probable cure; paranoid forms are the least favorable; hebephrenic are second least; the earlier the treatment, the better the prognosis.

Stutte (Germany) discussed prognosis in childhood and adolescence: 40 to 50 per cent of early childhood and prepubertal schizophrenics reach social, or even complete, remission. The schizophrenic episodes of adolescence have a less favorable prognosis. The progress of the initial symptoms seems to have some bearing on outcome; those with a slow beginning (premature schizophrenia with loss of speech and contact, and the hebephrenic cases) have unfavorable prognoses.

Zubin (U.S.A.) discussed prognosis and pointed out that before 1930, when somatic and organic treatments were not in use, there was an improvement rate of 35 per cent. Since 1930, 60 per cent have been found to improve with specific somatotherapies; but after five years, this improvement rate falls back to the previous 35 per cent level. The goal of psychologic and psychiatric investi-

gation insofar as prognosis and therapy are concerned is now to define and to delimit the sort of patient who could be expected to receive specific benefit from somatotherapy. Prediction of success in treatment for schizophrenia is by consideration of: (1) pre-morbid personality and character; (2) morbid status and type (including the following levels of behavior—concept, psychomotor, perception, sensory and physiological); (3) course of illness and (4) follow-up. It has been found that if perceptual ability is greater than conceptual ability, patients tend to improve, and, vice versa. It has also been found that the better the family background, the worse the outcome; this in part may be because these patients were originally the sickest patients.

Treatment

Kline (U.S.A.) reported that following the introduction of pharmacotherapy, instead of the expected 1956 increase of 10,000 patients for the country, there was a reduction of over 7,000.

Brill (U.S.A.) reported on the use of "tranquilizers": With the use of these drugs, the discharge rate from New York state hospitals was increased 23 per cent. Admission rates have not changed, and, to date, neither have readmission rates, although it is perhaps too early to draw conclusions from this latter fact. None of the phenothiazine derivates has shown itself more effective then chlorpromazine; those whose toxicity is markedly less have also tended to be less effective. The best over-all results with the tranquilizers are seen in chronic, long-term schizophrenics, especially females.

In a symposium on the same subject organized by Kalinowsky (U.S.A.), leading therapists from various countries were in full accord that none of the treatment methods available prior to the introduction of the new drugs can be discarded. They all emphasized that even the cumbersome insulin coma treatment cannot be given up. Some, e.g., Sargant (England), strongly advocate a wider use of psychosurgery. Sargant further reports that the more actively patients were treated with the older methods, the less influence the drugs exert on the hospital population and on the outcome of the treatment program.

Kalinowsky warned of some dangers in the use of the newer drugs. If they are used too long, he says basic symptoms will be masked so that emotional deterioration will progress to such

a degree that surgery can no longer be advised with any hope of success. In Kalinowsky's experience, insulin coma and electric convulsive treatment remain the therapies of choice in acute schizophrenia. Drugs, he reports, often merely cover the symptoms and prolong the disturbed state so that the patient becomes an unfavorable and late case for somatotherapy. Prolonged use of drugs before finally resorting to somatotherapy may delay response to the latter; further, the drugs may predispose to an increase of aggressiveness during ECT.

Cameron (Canada) reported on treatment procedures in chronic paranoid schizophrenics. Prolonged sleep for 30 to 60 days, with chlorpromazine and barbiturates in combination, was used with regressive or "de-patterning" ECT. During treatment, the patient becomes incontinent, is completely disoriented and makes no effort to achieve orientation with regard to time, place or person. Depatterning is timed to coincide with termination of sleep treatment. Then the patient is brought out slowly with ECT at a reduced rate. Within two to three weeks after sleep treatment termination a preventive program is begun with one ECT a week for the first month, then one ECT a month for the next two years. Meantime, psychotherapy on a limited relationship basis is begun. Relapses are treated with an intensification of ECT.

Browne (Singapore) reported on insulin therapy combined with desoxycorticosterone acetate. The combination was used because of the suggestion that prolonged coma and cardiovascular disturbances may be related to disturbed adrenal cortical secretion. One group of patients received 5, 10 or 15 mg. of DOCA daily throughout the course of insulin coma therapy. This group had no serious systemic complications; the main difficulties were laryngospasm and epileptiform fits. There were no prolonged comas, no cases of cardiac failure and no deaths. There was no need for interruption because of low blood pressure, high pulse or peripheral vascular collapse. In a control group undergoing insulin coma alone, 10 major emergencies were encountered (and six of these patients died). The total death rate in the control group was 1.0 per cent.

Binswanger (Switzerland) discussed Existential analysis in the treatment of schizophrenia. He holds that whereas psychoanalysis appeared as a reaction to inadequacy in treatment methods, Existential analysis appeared as a reaction to the inade-

quacy of the existing schools of psychopathology. The Existentialists conceive of schizophrenic episodes as times when it is impossible for the patient to conduct his own life within the stream of existence around him. The question is, how can one conduct a life impossible to conduct? The answer is: by substituting for the uninterrupted, objective sequence of experience a subjective sequence. Experience takes on a nonsequential character in the schizophrenic, who aims for mischosen ideals, which are incompatible with experience. Thus the sequential character of experience is shattered, and the schizophrenic becomes embroiled in alternatives which are impossible to fulfill. This leads to masking, imitation, eccentricity and mannerisms. Not being able to cope with life gives rise to anxiety, for the attempt at masking fails and the mischosen ideals cannot be achieved. Existential analysis consists of looking behind the symptoms for the specific modes of existence which determine those symptoms, and then guiding the patient from an uncharted existence into new roads which allow existence to proceed in an orderly sequence.

In the main, Existential analysis is represented by Europeans trained originally as psychoanalysts. Minkowski (France) pointed out that the Existential group does not consider itself divorced from the body of orthodox psychoanalytic therapy and method, but that it looks rather to Existentialism as giving a more extensive and practicable approach to the patient and his world.

Summary

The Second International Congress for Psychiatry, held in Zurich September 1 to 7, 1957 devoted itself to one large topic: "The Present Status of Our Knowledge About the Group of Schizophrenias." A report of the various plenary sessions, film sessions, section meetings, and symposia is presented, under the following headings: epidemiology (incidence, cultural and familial background, etc.), definition and etiology, phenomenology and nosology, course and prognosis, and treatment.

The congress accorded an opportunity for workers in various fields to meet and discuss problems of common interest, to compare findings, and to appraise their differences. Such a meeting was considered to be particularly important in the field of psychiatry, where variance of viewpoint from one country to another is the rule rather than the exception. Despite the occasional handi-

cap of language barriers, the congress was generally regarded as highly successful; and participants in the meetings found themselves richly rewarded by the panorama of progress in the field which the conference presented for their consideration.

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THERAPY AND THE PSYCHIATRIST*

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The shifting scene in psychiatry, as it might be described, has in recent years included the expression of considerable doubt as to the essential value of theory, concept and practice as we have known these basic areas up to the present. Percival Bailey,[1] addressing the American Psychiatric Association, leaves little, if one accepts his conclusions, in which constructive confidence can be placed. Dr. Bailey places his hopes for remedial understanding and treatment of mental illness in the chemical laboratory and in some substance to be developed there which will prove to be an effective replacement for the "ineffectual" psychotherapy, psychosurgery, electric shock therapy and chemotherapy presently employed.

A further "sign of the times" is the increasing emphasis which is being placed upon medication in psychiatry, in response to the advent of the tranquilizing drugs. The beneficial effect of these substances upon the disturbed behavior and mentation incidental to major mental illness has brought about a decisive improvement in the environment of the mental hospital. In many instances, there has been a marked reduction in the use of electric and insulin shock therapy; management of the chronic and disturbed wards is on a more predictable basis; and discharge rates have taken an optimistic turn. Maintenance of discharge status is in many cases accomplished by a continued program of medication; but it is true that a considerable percentage of patients are able to function in a community setting who would, without medication, require hospitalization.

This is, in a sense, a step forward but the broad acceptance of "tranquilizing" medication as a fundamental approach to the treatment of mental illness involves a departure from basic tenets which the authors of the present paper do not consider justified. Symptom control is an unquestioned advantage in many instances but it would be the writers' premise that it is now accomplished in considerable numbers of cases without any remedial change in the underlying illness. To begin to consider treatment by medica-

*This study is from the Veterans Administration Mental Hygiene Clinic, Providence, R. I.

tion a complete procedure, is a very possible danger, not only to the patient but to the physician as well. Reliance on medication carries in its train a possible devaluation of former methodology and of long-held concepts of the nature of mental illness and its treatment; and this possibility is one which has received inadequate attention.

To one who is concerned with the developing status of the psychiatrist, from the dual standpoint of his concept of himself and of his relatedness to his patients and the illnesses they present, there is a sense of slipping foundation, as one contemplates a lessening value in all that he has studied, learned and sought to practise. Replacement by chlorpromazine, reserpine and meprobamate is not reassuring. It is difficult to feel favorably inclined toward joining colleagues who limit their concern to successful symptom control, since, in this limitation, one says an essential farewell to dynamic psychiatry and the relief from illness that comes through insight into distortion, repression and resistance.

If reliance is placed on a satisfactory reduction of anxiety and tension, and their behavioral counterparts, as the criterion of adequate treatment and recovery, there is no need to concern one's self with early pressures, developmental traumata, the deviation or repression of instinct expression and the psychodynamic evolution of the personality pattern which has reached its final expression in the mental illness. By the same token, interest becomes incidental or transitory in the development of insight and in the alteration of behavior pattern through understanding of emotional response to stress. Such actual capacities of the recovered patient as might be indicated in psychological evaluation do not influence the appraisal of his recovery. Recovery is considered to be accomplished if the patient is able to integrate and to function with relative comfort in his work, social and family circle. The absence of complaint, the ability to conform and to fit into a pattern of personal and public activity which satisfies the needs of his situation—in effect the absence of demonstrable signs of mental illness —is the level to be sought in recovery based on symptom amelioration.

The authors' concern in the present paper is admittedly in relation to the function of the psychiatrist as it has evolved to the present. As a student of abnormal psychology, the psychiatrist has devoted himself to diagnosis, determination of appropriate

treatment and the return of the patient to his best possible level of function in the shortest possible time. Within the framework of these activities it has been necessary for the psychiatrist to be able to evaluate his patient's capacities and abilities, not only in relation to choice of treatment but also to determine desirable goals for therapy. A knowledge of the patient as a person, together with a familiarity with his life story, his accomplishments, his likes and leanings, as well as his intelligence and motivation, made up the background of the psychiatrist's choice.

In the interaction between the patient and the psychiatrist, the initial elaboration of symptoms was formerly an important early step. The effect of symptom on ability to function would then engage the attention of the psychiatrist and determine in large measure the choice of milieu for further treatment. There would be the additional question, in appropriate patients, of the desirability of the symptom as a stimulant or adjunct to motivation for treatment. A sense of well-being, no matter how produced, is not conducive to a sense of need to remedy the existing status quo. To the psychiatrist intent on bringing out the latent background of the manifest discomfort, the prescribing of relaxants has been a matter of concern related to the total problem of the patient, not simply to the question of symptom relief. Present emphasis on the inadequacy of accepted disciplines, together with the changing pattern of thought resulting from the broad use of tranquilizing medication, places the psychiatrist in a more anomalous position than has formerly been the case. It is the writers' contention, however, that the patient has not changed, nor has the illness which he presents.

The psychiatrist faced with the question of symptom control must, the writers hold, evaluate the probable tranquilizing effect of the medication in relation to the total problem of the patient as the psychiatrist sees it. The primary interest of the patient is in achieving a cessation of discomfort in the shortest possible time, and he will greet with ready acceptance the quieting effect of sufficient doses of one or another of the presently-popular ataractics. In most cases, the patient will also be only too ready to accept the medication as a lasting solution of his problems, if the psychiatrist advances the idea or, in all probability, if he offers no comment to the contrary. In addition, the patient who has experienced early relief from medication will not offer an unmixed welcome to the

need for psychotherapy, unless this need has been presented to him as part of the initial appraisal of his total problem.

The responsibility of the psychiatrist to his patient differs in no way from that of the physician in any other specialty. The wishes of the patient, his desire for one type of treatment or another, are to be considered; but the psychiatrist must determine the nature of the basic difficulty, its source and the most desirable and potentially effective treatment to be carried out. The treatment decided upon will be a reflection of the evaluation by the psychiatrist. The choice of chemotherapy as the principal approach to recovery carries with it the assumption that the difficulties in living that have terminated in the illness will either be solved or rendered innocuous by the control of symptoms. Pressures to which the patient has been subject, frustrations which he has been unable to overcome, situations to which he has been unable to adapt, will be remedied with the patient's return to symptom-free levels. This is to assume that the disturbing and destructive nature of the symptoms is essentially the illness itself, and that the patient's inability to integrate as an effective member of society is a result of the presence of the symptoms. With the control and eradication of his complaints and/or bizarre behavior and mentation, he will be able to return to former levels and milieu. Presumably, he will be able also to find a solution for difficulties in living which are a usual counterpart, in addition to the symptoms, of the mental illness.

The foregoing is not descriptive of psychiatric thinking up to the present. Mental illness has been ascribed to pressures and restrictions in the environment of the developing individual which have prevented growth to mature mental health. It is felt that personality function has been forced into deviate patterns, and reliance has been placed upon distorted concept, the net effect being the inability of the individual to take his place in society and to live in rewarding fashion as a reflection of personal and internal security. The final expression of the disproportion is in the symptomatology of the mental illness, whatever form this may take. The function of the psychiatrist as a student of abnormal psychology, has been to familiarize himself with the developing pattern of his patient's personality, and to determine, with his patient, the source and character of the distorted thinking. Remedial

change, through the application of the insight thus gained, has been the goal of psychotherapy.

The literature of the tranquilizing drugs has described them as most effective adjuncts to psychotherapy. There are, however, many articles and case reports in which chemotherapy and symptom control are described in detail, while psychotherapy, if reported at all, includes no material reflective of constructive change in personality pattern.

A recent brief case report circulated by a major pharmaceutical firm described the development of major apprehensions and ideas of reference to a degree that prevented the patient concerned from working effectively. Medication with chlorpromazine over a relatively brief period brought about a return of normal optimism and an ability to return to work with renewed enjoyment and capability. There is no mention of any endeavor to determine the source of the patient's disability, its place in the total pattern of the patient or its prognostic importance in relation to possible incipient mental illness.

Sole reliance on medication is further illustrated by a patient with paranoid schizophrenia of some eight years in duration who had been making a marginal adjustment despite expected and recurrent difficulties in social interaction, particularly with his employer. This patient demanded with considerable vehemence that he be supplied with some of the "happiness pills" that he had read so much about: "I gather from what I read that all I need is the right medicine, and all my troubles will blow away." Constructive rapport with this patient is conceivably dependent on the ability to supply him with a miracle drug, and his resistance to participation in therapy is augmented by the feeling that the interviews would be unnecessary if the physician would simply supply the proper medication.

A further example of disturbance of motivation and confusion of objective may be seen in a patient who had been informed at the termination of hospitalization that he must remain on chlorpromazine for the rest of his life. Improvement during post-hospital psychotherapy warranted a reduction in dosage, but the suggestion created concern in the patient as to his ability to control hostile thinking and impulsive activity. The ability to depend upon himself and to evaluate favorably his own progress in therapy had been severely limited by the "life-long prescription," and to

the therapist's load had been added the need to break down the patient's concept of himself as inadequate without the crutch of medication.

A final example is offered in the case of a patient who developed paranoid ideas with auditory hallucinations. Following medical discharge with the diagnosis of schizophrenia, paranoid type, in January 1953, he was rehospitalized in February 1953 for a period of three months. He was rehospitalized in 1954 and in 1956, each time for periods of approximately four months. In the intervals between hospitalizations the patient had been able to make only a marginal adjustment, living with his parental family against hospital advice and being employed, with long intervals of idleness, as a mechanic and as a woodsman. He has been seen as an outpatient irregularly, because of absenteeism, and has manifested over the three-year period discernible confusion, preoccupation, resentment and antagonism. He has described obsessional thinking, auditory hallucinations and paranoid delusions. He has used alcohol as a sedative and, repeatedly, before hospitalization, became assaultive, with consequent police intervention.

During his 1956 hospitalization, he was placed on 400 mg. of chlorpromazine daily, with early favorable response. At discharge, after four months in the hospital, a continued daily dosage of 300 mg. was recommended. Weekly psychotherapy interviews were advised, but he would not agree to more than two a month. After four sessions, there was evidence of increasing withdrawal, antagonism and preoccupation; and an assaultive incident occurred thereafter, with a resulting return to the hospital in 1957.

The foregoing case is offered in some detail, as it affords an excellent example of apparent improvement under medication with no collateral change in the basic illness. The repetitive history of hospitalization following reactivation of the paranoid illness demonstrates the need of tangible and verifiable improvement in the illness itself before further discharge can be considered. The descriptive summary of the patient's 1956 hospitalization includes the following: "Following his readmission he was immediately started on chlorpromazine and showed a good response with rather marked diminishing of his hostility and some increased insight." Further developments as outlined warrant the conclusion that the improvement under medication was more apparent than real, and that the need for investigative psychotherapy remained,

despite the lessening of overt hostility and the apparent increase in insight.

The foregoing is offered as exemplary of a treatment situation in which the constructive value of the psychiatrist to his patient remains in his ability to evaluate the true level of effectiveness of the patient's personality function. Favorable response to adjunctive medication is accepted as a collateral with optimistic indications but the psychiatrist continues, in the authors' opinion, to relate definitive progress to objective improvement in areas of basic distortion. One can agree with Hoffman,[2] in relation to the tranquilizing drugs, that "perhaps we will need more therapists and fewer attendants who function largely as guards; more activity space and less space for electric shock therapy, fewer wards with steel screens or iron bars; more social service workers and rehabilitation and vocational counselors." However, the authors cannot agree that the advent of the tranquilizing drugs has altered in any way the primary responsibility of the psychiatrist to continue to work to understand mental function and its aberrations, and to give dependable counsel to his patient in this regard. In summary, it may be said that a great deal remains to be accomplished in the field of psychiatry. It is possible that considerable impetus in treatment may result from the introduction of the tranquilizing drugs. However, initial enthusiasm in relation to symptomatic response is tending to lead us away from the basic aims of psychiatry.

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BRITISH PSYCHIATRY TODAY*

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Great Britain is separated from France, and the Continent generally, by the English Channel; early in the century an English newspaper published a headline which has since been held to typify the British attitude to the rest of the world. It stated: "Fog in Channel: Continent isolated." This reaction, however, is no longer truly representative of the British, who today are well aware that they can learn a great deal from other countries. In the field of psychological medicine, the English psychiatrist looks to the United States for a freshness of approach and an optimistic originality of method, but is sometimes disconcerted to perceive in certain American attitudes marked differences in orientation from his own. Some of these are probably due to dissimilarities in culture patterns, and in the practice of medicine, since the National Health Service has come into effect in the United Kingdom. Because psychiatric—as well as medical—treatment is available to all in Great Britain virtually without cost, it has to be spread out evenly and somewhat thinly, leading to some extent, to a neglect of the individual in the interests of the group. Thus, lengthy analytic procedures are not available in Britain under the Health Service, and if the patient desires them, he must go privately to an analyst; alternatively, he may decide to put his trust in less extensive psychotherapeutic maneuvers—which many British psychiatrists consider adequate in most cases.

The task of comprehensively representing a national viewpoint in an accurate and unbiased way is hard to achieve; but an attempt seems most likely to succeed if it includes a varied selection of relevant quotations from recent British writings interpreted in the light of personal experience. The result, the author feels, is like that of Montaigne.[1] "I have gathered together a posy of other men's flowers; naught but the thread that binds them is my own." In this case the author trusts that the bouquet is sufficiently varied, without gross discordancy, and hopes that it will not suffer from having been gathered in too small a meadow. In thanking those whose flowers are displayed, he wishes to assure them of his in-

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debtedness to them; and also to others necessarily unmentioned in this brief summary.

The United Kingdom Today

England, Scotland, Wales, and Northern Ireland today constitute the United Kingdom, the English and Scottish parliaments having united in 1707 and Southern Ireland having split away from its union with Great Britain in 1920. The United Kingdom has 51,000,000 people—about a third of the United States' population, packed into an area a thirtieth that of the United States. To serve this tightly-knit, insular, homogeneous population, uninvaded and undisturbed for 900 years, there were, in 1956, about 64,000 doctors, of whom some 40,000 were employed in the Health Scheme. America had, in 1956, about 220,000 doctors for 170,000,000 people.

The average working man in Great Britain today makes in the region of £600 a year but is, with this, able to buy much less than his American counterpart. Cars, for instance, are luxuries, and heavy direct and indirect taxation makes life a problem for the middle classes. This is partly due to the fact that since the Socialist administration of 1948, the country has been geared to an expansion of social services which many feel has been more than she could reasonably afford. The miner, for instance, drawing his £12 to £15 weekly for a job which is admittedly hard, difficult and dangerous, often lives in a subsidized house, eating subsidized food, with free education for his children, and free medical and dental care for himself and his entire family. In addition to the Health Service, the state provides National Insurance, family allowances, free school milk, low-priced school meals and child guidance. There are pensions for the old, the sick and the disabled, and employment services for disabled persons. National Assistance and legal aid are also available.

Comprehensive integration and development of social services in the United Kingdom along the lines of the Beveridge Report of 1942 came into full effect in 1948.[2] The services now available have three main features and some minor ones. In the first place, they provide family allowances as an incentive to increase the birth rate—every child after the first gets eight shillings a week out of taxes. Second, there is a National Insurance Scheme, contributions to which are compulsory, except for children, old people,

and married women; cash benefits include unemployment pay, sick and maternity benefits as well as retirement payments and widows' pensions and death grants. There is also an Industrial Injury Scheme, and all these allowances are supplemented by National Assistance where insurance benefits are not available or are inadequate for a minimum living standard. Contributions to the scheme are paid jointly by employer and employee and amount to six or seven shillings a week each. (This is $1 each at the present rate of exchange but, assessed at the actual worth of money to the average man, represents about $2.) Third, the National Health Service provides a comprehensive health scheme, with medical, dental, ophthalmological and hospital services available to all. The service is provided in the main without charge, but there are a few exceptions to this, such as a charge of one shilling per item on a prescription, up to £1 for dental treatment, and charges for about half the cost of dentures, as well as for spectacle frames and part of the cost of lenses, and contributions toward the cost of some appliances. There are, however, some exceptions to these charges.

Historical Background of British Psychiatry

Regrettably, discussion of the very interesting subject of the development of psychiatry in the Britain of long ago will have to be brief, and only the events of the last few years, which are germane to this thesis, can be dealt with at length. According to Henderson and Gillespie[3] the first "lunatics" were confined at the Royal Bethlem Hospital in 1403, lunacy legislation having first appeared in 1320, when the property of lunatics was vested in the Crown. In the eighteenth century, the cruel treatment received at a Lincolnshire private hospital by King George III, who suffered from recurrent mania, brought about the appointment of a committee of inquiry by the House of Lords, and this, in turn, led to greater public interest in the plight of the "insane" throughout the country. At the end of that century came a period of humane reform, initiated in Europe by Pinel's liberation of fettered patients in the Bicêtre Hospital in Paris in 1792. Four years later, William Tuke and Lindley Murray opened "The Retreat" at York, and the next century saw increasing legislative protection of, and interest in, the "insane," starting with Wynne's Act of 1808. Gardiner Hill and Charlesworth began to practise

nonrestraint at Lincoln Asylum in 1837, and their work was continued and carried on by Conolly at Hanwell, who, in 1856, published his book, *The Treatment of the Insane without Mechanical Restraint*. About this time, a visit to Scotland by an inspired American, Miss Dorothea Lynde Dix, resulted in the establishment of parochial institutions to care for the mentally sick there.

A progressively more humane approach to "insanity" led to its conception as a sickness requiring sympathy and therapy, rather than castigation and confinement. Institutions became hospitals where patients could be treated and helped, rather than places for secluding and detaining violent and dangerous deranged persons. An effort was made to improve the public attitude toward such hospitals, and a system of seclusion in single rooms, usually locked and padded, was substituted for mechanical restraint. But, of late, this system, too, has gradually been abandoned and has been superseded by an improvement in the quality and quantity of nursing and medical staff.

The atmosphere in British mental hospitals probably first began to improve in 1841 when Dr. Samuel Hitch, medical superintendent of Gloucester General Lunatic Asylum, brought in the wives of his married attendants to help with the patients; but it was to be 40 years before the first trained hospital nurse was appointed matron in an asylum. In 1841 too, Hitch founded the Medico-Psychological Association, later to become the Royal Medico-Psychological Association. This began as a society of asylum superintendents seeking to improve conditions for patients, provide training for mental nurses, and increase the prestige and skill of asylum doctors. The association instituted a training course and certificate in mental nursing—classes were started by Dr. Browne in 1854 at Crichton Royal Hospital, Dumfries—and its examination led to the production of a textbook of mental nursing by Dr. Campbell Clarke in 1881, *A Handbook for Attendants of the Insane*. According to Odlum,[4] the association was also largely responsible for the establishment of the diploma in psychological medicine (D. P. M.) as a postgraduate qualification for physicians practising psychiatry. Its official organ, the *Journal of Mental Science*, is published quarterly.

The present-day academic attitude in psychiatry in Britain was originated by a famous English psychiatrist of the late nineteenth century, Henry Maudsley, the founder of the London postgraduate

teaching hospital which bears his name. He had an inspired interest in "the philosophical history of insanity," and his views, therefore, led to British modifications of the prevalent German interest in describing and classifying mental illness. Stafford-Clarke[5] describes his approach succinctly as follows:

"While Maudsley was impatient of metaphysical speculation or even of introspective speculations in psychiatry, his regard for the brain as the organ of the mind had far wider implications than those of purely deterministic materialism. Believing indeed that structural and physiological processes were indissolubly linked with both normal and abnormal mental function he ascribed the whole interdependence of mind and body to one purpose, '... the will of God... manifest in its highest form and with least obscuration in the temple of man's body...'

"Working within this framework, he paid assiduous attention to all possible sources of physical and constitutional contributions to mental illness, particularly heredity and individual structure, although treating of the latter he remarked, 'The intimate chemical and molecular changes, which are presumably the conditions of mental disorder, go on in a domain of nature, the subtleties of which far exceed the subtleties of observation'... In his attention to the bodily element in the body-mind relationship, Maudsley did not neglect either the influences of environment, or the possible effects upon structure of abnormal function. Indeed, by precept and example, he laid the foundation for that comprehensive approach to the individual patient, which remains to this day the most reliable method in clinical practice.... The value of this approach lay not so much in its philosophy or classificatory skill, as in its insistance upon detailed historical and clinical studies of every single patient..."

In his Goulstonian lecture of 1870, Maudsley said, "The observation and classification of mental disorders, have been so exclusively psychological, that we have not sincerely realized the fact that they illustrate the same pathological principles as other diseases, are produced in the same way, and must be investigated in the same spirit of positive research. Until this be done I see no hope of improvement in our knowledge of them, and no use in multiplying books about them."

The Maudsley approach dominates many university departments in Britain today, though by no means all of them; it is found un-

satisfactory by the more analytically-oriented psychiatrists. It is also different from the more Kraepelinian-Meyerian approach which persists in many mental hospitals.

The two most striking factors in the development of the mental hospital as it is today in Great Britain were the passage of the Mental Treatment Act in 1930, and the incorporation of the Mental Health Services under the National Health Service when this was instituted in 1948. The Mental Treatment Act enabled patients to enter and leave hospitals voluntarily, removing the stigma of certification, and mitigating, to some extent, the feeling of compulsion and restriction that the mental patient suffered prior to its inception; it led to open door policies and other nonrestrictive practices and to the more enlightened attitude toward mental patients that now prevails in British mental hospitals. The fact that positions have become available for psychiatrists in mental hospitals and teaching hospitals under the National Health Service, has meant that senior psychiatrists could afford to continue to work in hospitals and devote their time to clinical duties, rather than move —for reasons of higher salary—into private practice or into administrative positions in mental hospital management. Private psychiatric practice indeed is rather rare throughout Britain, and the prestige with which the teaching hospital appointments are endowed results in a good deal of competition for these posts; some of them do allow limited private practice.

According to Tooth[6] there were 174 mental hospitals in England and Wales, under the National Health Service in 1953 and these contained about 97 per cent of the hospitalized mentally sick patients in their territory, who totaled about 150,000 in all. About three-quarters were certified, and many of these formed an unchanging substratum of permanent inmates; about half were schizophrenics or paraphrenics, and a third were over 65, with a preponderence of females. There was an average of 15 per cent of overcrowding,[7] and there was an average over-all death rate of 8 per cent. Of the noncertified patients, the vast majority were of voluntary status, and the 20 to 25 per cent of beds not occupied by long-stay patients saw a large turnover of cases. So great was this proportion of noncertified patients, that 70 per cent of the new admissions were voluntary, as were 82 per cent of the discharges; and the rates in the best mental hospitals today are higher still than this average. With regard to these and other matters, the

present state of affairs has been studied and presented by Kalinowski[8] in a recent paper.

Besides mental hospital beds, about 3,000 extra beds were available in 1953 in England and Wales. These were attached to general hospitals or teaching hospitals or were in "neurotic units"; patients in these beds were voluntary, or were temporarily detained under legal orders for observation; these beds had a considerable turnover of cases. Most British university teaching hospitals now have departments of psychological medicine, and in some of these, an analytic approach finds favor, although in many, a Maudsley multidimensional orientation is practised.

In Britain generally, physicians from the mental hospitals make up the staffs of the outpatient psychiatric clinics and the follow-up clinics in the general hospitals; and most of the positions for psychiatrists are in the mental hospital service. Their contracts usually preclude private practice. There is not much faith in preventive psychiatry, though there are some signs of an awakening interest.[9] An effort is made, however, to keep patients ambulatory in the community as long as possible—until their behavior becomes unacceptable or there is an adequate therapeutic reason for admitting them to hospitals. Neurotics are treated as outpatients as far as can be managed, or if they are admitted to hospitals spend short periods of a few weeks in units which endeavor to break predominant vicious circles—insomnia, weight loss, and so on—and to push them back into the community, where they can often function adequately with support. The results obtained with vigorous short term treatment at Roffey Park Rehabilitation Center have been published by Ling, Wilson and Briggs[10] and typify the success that can be achieved by these methods; about two-thirds of the patients who had been hospitalized were found to be well adjusted to work when followed up two to seven years after discharge. In addition, a few of the more intelligent neurotics are selected for long term psychotherapy by those specially interested in this approach; and in the large cities such as London, more extended psychotherapy is available for those who can afford it. Child guidance clinics are less numerous than in the United States —which gave them birth—and the first ones in Britain started in the 1920's.

One or two "neurosis hospitals" predate the First World War, but most of the English concepts of neurosis stem from that war

experience, and, after it, a few "neurosis hospitals" were set up in large cities. The Maudsley Hospital, which, in Britain, is the Institute of Psychiatry, and forms the postgraduate teaching hospital in psychiatry of the University of London, came into being in 1923; and about this time, too, the Cassel Hospital, run on more analytic lines, was founded. Jordanburn Nerve Hospital for neuroses and acute psychoses was established at the University of Edinburgh under Sir David Henderson, who had worked under Adolf Meyer at the Phipps Clinic from 1912 to 1915, and whose *Textbook of Psychiatry,* written with the late R. D. Gillespie, remains a highly regarded standard British text on the subject.

For a number of reasons the various analytic schools have not come to dominate the British psychiatric scheme in the way psychoanalysis has been integrated with psychiatry in the United States. The idea that mental disorder originated in disturbed interpersonal relationships—instead of producing them—was regarded as too narrow by the constitutionalists, who considered such relationships only one aspect of the problem. The early believers in analytic methods, crossing the Channel, found a solid body of medical tradition that did not exist on the American side of the Atlantic. Perhaps the fog had something to do with it! More important than this, perhaps, was the fact that the European analysts were dominated by their founder who frowned on much deviation from his methods. In America, a younger, more vigorous and less hidebound culture permitted freedom for experimentation—and this out of reach of the master's reproving eye. This perhaps explains the amount of work that has been done in the United States in the application of analytic methods of investigation to psychosomatic problems, work which has not been paralleled in Britain. But analysts, of course, did settle in Britain, and continue to flourish there, practising whatever doctrine they may adhere to, and giving instruction to psychiatrists and physicians interested in these areas of investigation.

Having had little contact with analytic schools, the author is ill equipped to discuss their organization, but he was recently in touch with the Institute of Psychoanalysis in London, which is the center for teaching and training in psychoanalysis in Great Britain. The institute asserts that there are 146 psychoanalysts in Great Britain of whom 102 are medically qualified; in the United States, there are more than 600 psychoanalysts who are so quali-

fied. The Tavistock Clinic and the Cassel Hospital are two well-known centers of psychoanalytic teaching in the United Kingdom. In recent years a good deal of work has been done at the Tavistock Clinic by Balint[11] and others in the very necessary and worthwhile task of training general practitioners in psychotherapy; and several papers have appeared, testifying to the success of the evening seminars held there for this purpose. Jungian psychology is represented by the Society of Analytic Psychologists, which has 41 members, 23 of whom are medically qualified, and there is also an Adlerian Society of Great Britain. In addition, there is an Institute of Social Psychiatry in London, run on Adlerian lines, of which Dr. Joshua Bierer is director. Most of these institutions insist on a personal analysis of the appropriate type, in addition to carefully supervised analytic treatment of cases, as part of their training curricula. Full-scale analysis is not practised under the Health Service but a number of analysts are employed by the Health Service in teaching, giving therapy to neurotics, and so on.

The National Health Service

The National Health Service came into effect in 1948 and currently[7] costs about £500,000,000 annually, or about £10 a year per person; in 1955, four-fifths of this was met by the Exchequer out of moneys voted by Parliament. Some of the financial support comes from National Insurance, which is compulsory in most cases, and, as has been mentioned, costs employer and employee the equivalent of $1 to $2 a week each. The Health Service provides medical, dental, opthalmological, and hospital care, which is virtually free and is available to all; the staff is about 40,000 doctors. General practitioners are paid on a per capita basis, supplemented by certain allowances and additions; the average practitioner's earnings in 1955 were given as £2,200, and the cost of the average prescription was in the region of 4/6d. (about 65 cents).

For psychiatry, the incorporation of the Mental Health Services under the Health Services has been a great step forward, and already some of the "starvation" of past years is being rectified. Too long the Cinderella of medicine, the mental health service is now getting a fairer share of available resources. More specifically, in 1952, the cost to the nation of the mental hospitals, state institutions, and Maudsley Hospital, with the salaries of psychia-

trists, was £46,000,000. Fears that the cost of the service might soar prohibitively have never been realized, and the Guillibaud Committee,[12, 13] set up in 1953 to review costs, said in its report in 1956, that the cost of the service was "clearly if not severely under control," and further stated, "The population changes estimated for the next 25 years give no cause for concern."

In hospitals, the stratification of junior full-time staff is uniform in all branches of medicine, and it is customary for the doctor intending to specialize to ascend gradually to consultant rank through the registrar grades, which normally cover seven years. Usually the new medical graduate—there were 1,874 in 1955, out of 2,816 candidates for the final examinations—serves an internship for a year and then spends two years in the armed services as a medical officer. He then attempts to get the best possible training position as a senior house officer or junior registrar, which lasts a year, and pays £745. Next, he spends two years as a middle registrar, with more responsibility and a slightly higher salary; and, subsequently, providing he obtains the appropriate qualifications, becomes a senior registrar. This position is held normally for four years, and the salaries range from £1,100 for the first year to £1,400 in the final year. There were 1,094 senior registrars in the Health Service in 1956; and they, like their juniors, were full-time employees, not permitted to practise privately. However, the position carries with it considerable freedom, and a minimum of six weeks annual vacation, which is the rule in the Health Service in all grades above middle registrar. The final step—far from easy in many specialties—is consultant status —which may be on a full-time or part-time basis and is paid on a salary scale of £2,100 a year, rising to £3,100 on a full-time contract. It should be made clear that there is still a great deal of competition in many specialties in grades above middle registrar, especially for positions in the better hospitals and the wastage rate of semi-trained specialists is not inconsiderable. This is a source of anxiety for those intending to specialize. They fear that they either will not attain the appropriate positions, or that there will be no consultantships at the end of their training; or, again, that they will not be able to enter general practice under the conditions they desire. A prolonged period of uncertainty and financial hardship has thereby been imposed on the trainee-specialist; and many frequently reiterated complaints, though justifiable,

have not led to any amelioration of this situation. This problem is a considerable one in general medicine, surgery, gynecology, and pediatrics, but is not so pressing in psychiatry. There were in 1956, in fact, 6,650 consultants in the Health Service, with an average salary of £3,500 annually, and a third of these received one of the three grades of merit awards that range from £500 additional to £2,500 additional annually. Besides these classifications there are junior and senior hospital medical officer positions available for physicians who are unsuitable for training through the registrar grades, and these are paid appropriately. Hospital personnel receive pensions on retirement from the Health Service at the age of 65, or of 60 in the Mental Hospital Service.

Despite various complaints from the doctors about the present scale of their remuneration, the Health Service from the patient's viewpoint seems to work tolerably well, and does not seem to have impaired the relationship between patient and doctor. Under the Health Service, few patients consult the average psychiatrist directly, and he treats them through the medium of, and with the full collaboration of, the general practitioner. Indeed the general practitioner in Great Britain seems to be growing slowly more "psychiatry conscious" and a number of articles have appeared on the scope of psychotherapy in general practice.[14] In a recent paper by Paulett,[15] the incidence of neurosis in the patients in his general practice over a five-year period was of the order of 70 per cent, but only a few of these cases, of course, were referred to psychiatrists. He regarded the symptoms as signifying that a patient was suffering from emotional strains and needed to adjust his way of life to avoid them. He went on to suggest that research into the etiology of neurotic ill health should begin in general practice. As a patient quoted by a Lancet peripatetic correspondent[16] declared, "My doctor says it's my nervous system. Well my nervous system has been to worry a lot about nothing—which is a difficult system because I have nothing to worry about, but now I know, I don't worry about the headaches."

Graduate Training in Psychiatry in Britain

Upon deciding to enter psychiatry—usually about three years after graduating—the intervening time having been taken up with internship and military service, the doctor obtains a house officer position or middle registrarship at a good mental hospital or in

a teaching hospital department. As far as possible, applicants for positions are chosen who have had all-round experience in medicine; a knowledge of neurology is an advantage. The candidate works for the diploma of psychological medicine, which corresponds roughly to a certificate of an American Specialty Board, and without which, he will not get very far in psychiatry in Britain. The examination involves a written and oral first part covering neuro-anatomy, neurophysiology and psychology. In psychology, the candidate is usually expected to be familiar with current psychological theory, psychological testing and the various analytic theories. Then after experience in child psychiatry, mental deficiency, and neurology, as well as in general psychiatry, the second part of the examination is taken. This has written, oral, and clinical parts in neurology and psychiatry. Though many universities give this diploma, the standard is fairly uniform, and the passing rate is about 45 per cent.

Many university departments of psychological medicine give courses to prepare for the examination; for instance, the University of Durham has a part-time course of two afternoons weekly for a year in the subjects for Part I; during the second year there is a full-time six-month course of lectures, demonstrations and conferences for Part II. The Institute of Psychiatry at Maudsley Hospital has a fairly intensive course, full time, for three years, for the London D.P.M., which is the best of these diplomas. With a D.P.M., an applicant can get a registrar appointment at a teaching hospital, or perhaps a position as senior hospital medical officer at a mental hospital. He is unlikely to attain consultant rank in either sphere with this diploma alone.

This might be an appropriate place to mention that generally in Great Britain there is no wide dichotomy between teaching hospitals and mental hospitals. At the University of Durham department of psychological medicine at Newcastle-on-Tyne for instance, weekly conferences are open to all the psychiatrists in the area, and they try to work together as closely as possible. Similarly, no psychiatrist is believed properly trained unless he has had mental hospital experience at some time in his career; this is felt to be essential for a balanced psychiatric viewpoint.

A rather complicated system of higher qualifications pervades British medicine and in the three main specialities, medicine, surgery, and obstetrics, the various Royal Colleges provide exami-

nations for the higher qualifications they bestow. As psychiatry is closest to medicine, the British psychiatrist is expected to have a better than average knowledge of medicine and neurology, and it will be advantageous for him to attempt to become a Member of the Royal College of Physicians of London, Edinburgh, or Ireland by taking the appropriate examination. The London membership examination is a written, clinical, and oral examination in pure medicine, and has a passing rate of 12 to 15 per cent; the Edinburgh membership requires a high standard in a selected subject—such as psychiatry—in addition to a stiff examination in general medicine. About 15 to 20 per cent of the Edinburgh membership candidates pass. The Irish membership examination is run on similar lines. Because these examinations are extremely difficult, and are expensive to take, they form a considerable stumbling block for the would-be specialist; often he has to make several attempts and may have to attend special courses. However, he will have to resign himself to the fact that if he is to get a senior position in the academic field in a university, or, alternatively, a consultantship in the best mental hospitals, he needs one or another of these qualifications as well as a D.P.M. They form a stimulus for work at a critical time in his career, and provide for a modicum of respect from physicians and others, who, in Britain anyway, are apt to feel that psychiatrists know very little medicine and are only interested in their own rather peculiar theories, "the investigation of the id by the odd," as some wag put it. In due time, after some years, and after some contribution to medicine has been made, the more senior members of the colleges are elected fellows.

Some sort of substitute for the Royal College membership is provided by the M.D., which must be taken at the university from which one was graduated; this is a higher qualification than that required for practice, and is granted usually on a thesis based on original clinical research. If the physician has the M.D. or a Royal College membership before entering psychiatry, he is in an advantageous position and can concentrate on the D.P.M. It is probably more difficult the other way around; but, in a way, many feel that this reverse procedure is no bad experience for a doctor intending to become a psychiatrist.

General Psychiatric Orientation in the United Kingdom

I. *British Mental Hospital Practices*

In recent years there has been a move away from the confining, repressive type of mental hospital care with all the problems this engenders. The idea of a "confinement psychosis" has pervaded the thinking of many of the more liberal-minded mental hospital psychiatrists, and their attitudes have altered accordingly. Clark[17] has described in a lucid paper the functions the mental hospitals are constrained to fulfill in Great Britain at the present time, and has given an insight into the ideals of those who run them.

He regards the function of the mental hospital as falling broadly into four special categories, in that it has to care for four main groups of patients. These are: (1) the acute social and mental breakdowns (the observation ward function); (2) the aged disturbed patients (the geriatric hospital function); (3) the court cases (the hospital-for-psychopaths function); and (4) the neurotic illness (the neurosis-center function). It is apparent that the observation ward function will have to be maintained in most areas other than large cities, though better initial classification through extended domiciliary consultations may cut this down in time. Better community care and more active social welfare programs may lessen the geriatric problem, especially when more geriatric units become available. With the third group of patients —the court referrals, often basically psychopathic—the mental hospital does not usually have much success; and their presence in the hospital militates against ameliorating conditions in ways found helpful to the other types of patients; separate provisions for these cases are really needed. The ideal solution for nonpsychopathic patients, Clark feels, is the establishment of a hospital with a minimum of restrictions as a therapeutic community on lines established by Rees in England and Sivadon in France.

In a monograph written with Sivadon and others, Rees[18] has lately described the effect of applying open door policies in his hospital at Warlingham Park near Croydon; so impressive have been his results and so changed is the attitude of the public to the mental hospital in this area, that the freedom of Croydon has recently been bestowed on him by the grateful townspeople. Happily, the sort of methods that he advocates are more and more pervading British mental hospitals; doors are being opened everywhere, and patients afforded more freedom. As Rees has indicated, this

is a hard task because of the anxiety of the staff; and it necessitates constant meetings between staff and patients, detailed employment schedules, intensive habit-training schemes and the application of physical treatments, such as ECT, insulin, and lobotomy when necessary. Using similar methods in Dingleton Hospital at Melrose, a small Scottish border town, Bell[19] has been able to abolish locked wards entirely. A recent description of a visit to the mental hospitals at Warlingham Park, Netherne and Dingleton has been given by Koltes.[20] It is of interest in providing an external assessment of their methods in operation, and it should be consulted as valuable, impartial objective testimony.

With the need to provide for the bulk of patients, group treatment is gaining in popularity and Beirer's work[21] in starting clubs in mental hospitals (at Runwell Hospital in 1938) has gained in importance. There are now more than 50 inpatient clubs in Great Britain for all classes of patients and these have produced noticeable improvement in behavior and general demeanor in patients participating in club games, dances and occupational therapy. In a recent article on this topic, Kathleen Thompson[22] remarked, "surely it is worth while to make every effort to keep even the worst patients in as much contact as possible with the normal way of life; to stimulate them and to keep them up to the highest possible standard of behaviour..." and later, "We are told that the group and group treatment have a cathartic effect on the schizophrenic and a very large number of patients in these wards are labelled 'schizophrenia.' This itself provides a strong argument for using this approach in their treatment. Establishing contact and gaining cooperation from these patients is often difficult but the author is convinced that their period of 'awareness' to the environment, whether long or short, can be stimulated and sometimes lengthened through the less demanding situations of play and while the attention is stimulated by the often forgotten patterns of childhood play, further and more adult activities can be introduced. Then as this is done repeatedly, the staff can take a less and less active part, intervening only when interest lags and reanimation becomes necessary."

Maxwell Jones' work[23] with therapeutic inpatient communities is probably already sufficiently well known in America to require no further amplification. Perhaps less generally realized is the stress he lays on the value of work therapy[24] as opposed to what

he regards as the more "exotic" varieties of occupational therapy. The social rehabilitation unit he initiated at Belmont after the last World War started with bricklaying, plastering, carpentry, hairdressing, gardening, and tailoring, but the patients grumbled and felt these occupations were of little value to them. Accordingly, groups were formed in occupations to meet the needs of living in bomb-damaged buildings. These occupations comprised (1) furniture repair (2) painting and decorating (3) gardening (4) tailoring, and (5) home duties. The patients' attitudes rapidly changed; they suggested and put into effect weekly workshop discussions with their social therapists, instructors, and nurses, and discussed problems of absenteeism, lateness, etc. The group assumed responsibility in these matters; the (rather meager) rates of patient remuneration were seldom discussed. The belief that female patients would be interested in marriage, housework, childbirth, etc. was found to be mistaken. The women at the Belmont unit wanted to work with the men and not in isolation. When this was realized, their presence was welcomed by the men, and handicrafts ceased to exist as a female occupation in the unit.

Maxwell Jones remarked in a recent article[24] on this topic:

"Many occupational therapy departments give much help to the more ill or dependent patients, but when rehabilitation has reached the stage of preparing them for ordinary work, a group task involving production of social value is to be preferred to individual tasks carried out in relative isolation in the handicrafts department. It is not enough to get the patients to do something: They must be helped to identify with the staff and the ward environment and given some choice in what they want to do. If the staff are willing and able to identify themselves with the patients, a shared task and a social experience can be therapeutic."

The gist of the present day British mental hospital attitude, then, is really the concept that the main problem in treating mental hospital patients is posed by the few who are turbulent and the many who deteriorate. The bulk of long-stay patients are schizophrenics or paraphrenics who are known to be susceptible to environment; it is believed they can, in the first instance, be prevented from becoming chronic patients, by an improved patient-nurse relationship within a self-supporting community with open doors. A dependent state of institutionalization can and must be avoided, as has been stressed by Martin.[25] Recently Cameron

and his colleagues[26] have again demonstrated what can be achieved in this way with skilled nursing, which is indeed the rule in the better mental hospitals in Britain; but unfortunately the efficacy of physical treatments in the control of difficult behavior problems, and more recently the "panacea" of the tranquilizers has led to some neglect of this principle of good nursing. The situation, however, is not so black as the title of an article by Hunter[27] suggests: "The Rise and Fall of Mental Nursing." In it he quotes Conolly,[28] whose words take on an added significance a century after they were written: "The physician who justly understands the non-restraint system well knows that the attendants are his most essential instruments. ... They may be considered indeed his best medicine. ... He confides the most confidential duties to them: He entrusts them with the happiness by day and by night of all patients under their especial care: To control the violent without anger; to soothe the irritable without weak and foolish concessions; to cheer and comfort the depressed; to guard the imbecile and the impulsive, and to direct all."

As occupational therapy, work therapy and nursing have been referred to, an attempt must be made to delineate the place of the psychiatric social worker and the clinical psychologist in the scheme of things in British psychiatry. The social worker is generally regarded as being indispensable and of great value in obtaining histories from relatives, helping them with their problems, arranging social assistance and co-operating with the doctor generally. The psychologist, too, plays an important role, but in England, more in the sphere of testing than treatment: For one reason or another the mental hospitals seem to have too few psychologists, though, through the Health Service, a sufficiency of young doctors learning psychiatry is usually available. In the universities, psychologists do research; and they teach undergraduate and postgraduate students in psychology and psychiatry.

Finally, it may be remarked that personal experience in mental hospital work leads the author to believe in the efficacy of open door methods of treatment. In the large London mental hospital in which he held a junior position for a year in 1951, only a few wards on each side were open: Now 90 per cent of the female wards are unlocked as are 95 per cent of the male wards; and, having visited the hospital from time to time recently, he feels certain that it is a happier and more effective hospital than it

was in 1951. Some of the staff paid visits to Warlingham Park Hospital in 1952, and Rees' ideas were put into effect soon afterward.

II. *General Academic Orientation*

Though the following remarks regarding the general academic orientation in psychiatry in Britain may seem critical of certain current American concepts, they are not intended primarily as criticism, but merely as a means of giving insight into the British attitude. Moreover, the author does not necessarily agree with everything that will be cited.

An accurate idea of contemporary academic trends in British psychiatry can be obtained from *Clinical Psychiatry,* by Mayer-Gross, Slater and Roth[29] and *Physical Treatment in Psychiatry,* by Sargant and Slater,[30] and an attempt must accordingly be made to explain the general attitudes those books promulgate. Rather extensive quotation has been necessary for this purpose, and the author would again like to make due acknowledgment to the writers of these texts. Mayer-Gross, et al., in their very full introductory chapter, refer to the main task of psychiatrists as being "the attempt at comprehension of observable facts," and refer to "the subjectivity" of psychiatrists and ". . . the lack of precision of psychological data. Mental events can only be described in words which are themselves open to varied interpretations. Many terms used in psychiatry are taken from everyday language and not clearly defined. Special terms on the other hand have been taken over from psychiatry into ordinary speech, so that their meaning has been watered down and become ambiguous. Much of the psychiatric literature of today owes its existence to the possibility of playing with words and concepts and the scientific worker in psychiatry must constantly bear in mind the risks of vagueness and verbosity."

They go on to say:

"In this country [England] before the First World War, whoever took up psychiatry was considered a failure, a man unable to make his way in medicine and surgery. Psychotherapy was regarded as identical with charlatanry and the institutional psychiatrist as only fitted to act as society's custodian of its degenerate or dangerous members. That this has now changed and that the psychiatrist is recognized as a physician of standing, as well as a counselor in social problems of general interest, is due

to the cautious industry of responsible research workers and to the impartial collection of careful clinical observations."

These writers deprecate the tendency they see developing to "divorce psychiatry from the parent science of medicine," remarking, "The solid acquisitions of knowledge from the past, where they conflict with current modes of thought are not being reformulated, but are being neglected and even forgotten." They feel there is a tendency to a decrease of self-criticism among psychiatrists, resulting in too much never-validated theorizing, and they advocate as "a natural corrective to these unhealthy tendencies . . . a return to the bedside and to the discipline of clinical observation." The authors believe that when psychiatry leaves the study of a sick patient, psychiatry ceases to be psychiatry.

To describe psychiatry, as Masserman has done, as "a science of behavior," aiming "at giving a complete account not only of the clinical disorders that provide the daily work of most psychiatrists, but also of human motivation and behavior as manifested in social and political life, in art and religion," involves (in the opinion of Mayer-Gross et al.) "a grandiose and unwarranted expansion of the scope of psychiatry." They feel the psychiatrist must concern himself principally with the study of mental illness, also that excessive preoccupation with individuals is heuristically sterile, for progress depends on recognizing similarities between phenomena for which general causes can be deduced. They remark:

"If we forgo the making of a diagnosis we also forgo all application of the extensive knowledge which has been accumulated in the past. This were sheer folly: We cannot willfuly ignore what is known, and if we wish to do so, we are under the psychological necessity of proving or believing that the knowledge is false knowledge, or . . . that it is irrelevant. If we refrain from diagnosis we shall be left in the individual case without the help of general concepts. The wise physician never neglects the individual peculiarities of his patient, but he will first see how far he can be fitted into general patterns, and he will not mistake a quality which is characteristic of a group such as thought disorder or auditory hallucination as either without significance or as something to be interpreted by the life history of that one patient alone." They go on to say, "The contemptuous attitude towards diagnosis which is so prominent a feature of many contemporary schools, runs counter to the entire spirit of medicine. For diagnosis, properly

understood, has never been only naming and labelling. Ideally, it implies judgment of causation, and even if this is impossible for lack of knowledge it always includes a plan of action, i.e., treatment."

Mayer-Gross and co-authors define psychiatry as "that branch of medicine in which psychological phenomena are important as causes, signs and symptoms, or as curative agents," and feel Curran and Guttmann's definition as "that branch of medicine whose special province is the study, prevention, and treatment of all types and degrees of mental ill health, however caused," represents an undue expansion of the field. They say, "If the psychiatrist claims because he can understand certain human problems, that his concepts can be expanded and applied to human behavior as a whole, he will misjudge the range of his hypotheses and land in superficiality and error. His inordinate ambition will drive him by facile psychologizing to obscure rather than illuminate aspects of life with which he has no special acquaintance. His day to day work is with persons behaving in an abnormal or at least unusual way and this gives him a bias in perspective. Making use of the notions with which he is familiar, he tends to regard quite normal phenomena as pathological. Even within the field of psychiatry it is easy to misapply concepts in this way and much of what has been written on the subject of neurosis is vitiated because the underlying mechanisms were regarded as pathological. If any phenomenon such as the occurrence of anxiety is almost universal to the human race, then it is not to be explained by morbid mechanisms. Still more, then, it is likely that concepts taken from mental pathology and applied in such fields as anthropology and sociology, will shed a delusive light. We should, rather, proceed in the opposite direction, and try to map the range of normal variation before we feel sure of what is abnormal. Unfortunately, for obvious reasons, little has been done in this way." What is mental health? Studying this problem, Monro[31] chose 200 patients and rated them for 246 traits, allocating them into 36 groups. From an abstraction of opposites he adduced the following six characteristics: (1) integrity, (2) intelligent originality plus initiative, (3) good manners, (4) clarity of mind, (5) forthright good humor, and (6) emotional effervescence.

Mayer-Gross, et al. continue:

"The contrary tendency, to confine psychiatry to such an aspect

of behavior as interpersonal relations, is nearly as fallacious. Anatomical, physiological, biochemical, neurological and other modes of investigation are thereby excluded or regarded as of secondary importance, when they can contribute much to our understanding. The definition of psychiatry so framed is really a cloak for a hypothesis of the causation of mental abnormality, namely that it is due to disturbances of emotional relationships between individuals." They go on to point out the need "to delimit the concerns of psychiatry from those of psychology, the social sciences, general medicine and neurology."

After reviewing these relationships, they consider briefly the various schools of psychiatry, starting with Kraepelin, Wernicke, and Meyerian psychobiology, and proceed to a consideration of psychoanalysis, which they feel lacks "adequate scientific foundation," though they state, "the magnitude of Freud's achievement should not be minimized." It is inappropriate here to detail criticism of Freudian theory and its derivatives, but Mayer-Gross, et al. believe that "there is very little sign that further new fundamental contributions are to be expected from members of his school," and they remark that "it is something of a paradox that psychoanalysis continues to grow in popularity." They surmize that this might be due in part to the heuristic value of the theory and the possibility that the theory provides "certainty for those who cannot bear to be alone in the dark."

They go on to consider in some detail the need of the psychiatrist for a general theoretical schema and feel that, as the material available is so varied and is constituted of such paradoxical qualities, several different dimensions or ordinates are required—a multidimensional approach is needed. Some of these dimensions would include genetic aspects, age, environment in its physical and psychological aspects, individual variation, and so on. They state, "For multidimensional diagnosis in psychiatry it is not only essential to have the knowledge of symptoms and signs and an idea of their common occurrence and combinations in clinical pictures, but also to be able to range their specificity, their significance, and their relation to situations in the various phases of human life." This multidimensional viewpoint provides room for new observations and obviates the acceptance as general of a partial or narrow theory.

NEUROSIS, PSYCHOPATHY AND PSYCHOTHERAPY

The approach to neurosis and psychopathy of Mayer-Gross, et al. is to include both together under Schneider's definition, "abnormal personalities who suffer from their abnormality or cause society to suffer." They conceive of psychopathic and neurotic behavior as having its roots in normal behavior, differing from it only in degree, and able to be comprehended as a distortion of normal psychology—a development of personality in the sense of Jaspers, as opposed to a disease process. This, showing something new and strange—in form, if not in content—cannot be deduced from what is known of a patient's personality, age, and circumstances. Thus, from the hereditary endowment, constitution, and early conditioning factors in the patient, one can comprehend neurosis or psychopathy as logical and consecutive developments, but no amount of study will enable one to understand the form of certain psychotic mechanisms—such as delusions or hallucinations—which occur in psychoses. This distinction between development and process is felt to be of great value in psychiatric diagnosis.

In their chapter on psychopathic personality and neurotic reactions, they discuss, after a historical introduction, the etiological aspects of constitution and describe "special forms of reaction and of personality." The extent to which normal persons show these reactions, and their physiological bases, are considered in each instance, followed by an account of the relation between the reaction and other psychiatric states, the nature of pre-disposing and precipitating factors, clinical features, and diagnostic, prognostic, and therapeutic considerations. The reactions so described are the depressive reaction, the neurasthenic reaction, the anxiety reaction, hysteria, anorexia nervosa, obsessional states, irritability, hypochondriasis, and paranoid reactions. Among personalities, unstable drifters, the cold and emotionally callous, and the sexually perverse are also dealt with, and the section closes with a discussion on psychotherapy in the disorders discussed.

The authors feel that psychotherapy in neurosis is still to a large extent an empirical procedure essentially involving, "a relationship to the patient that is based on respect for his personality, a tolerance of his difficulties, and a sympathy and understanding for his predicament." They state, "The establishment of such a relationship with a neurotic patient requires more than psychiatric experience. It demands humanity, wisdom, maturity, and

empathy." Slowly the patient is brought face to face with himself in a therapy which leaves decisions and future plans to the initiative of the patient. The authors mention the use of chemical abreagents in loosening inhibitions and think that interviews lasting 40 to 60 minutes once or twice weekly are quite adequate for most cases. They mention the exaggerated attachment the patient comes to feel over a long period of treatment toward the person to whom he has unburdened himself and remark, "This may change, particularly when things are going badly, to an exaggerated hostility. It is reasonable to assume these attitudes may represent the patient's conditioning in relation to individuals endowed with an authority and social prestige similar to that of the psychiatrist, but there is no good reason for supposing that they involve in every case a revival of conflicting feelings identical with those experienced towards one or other parent in childhood as suggested in the analytic concept of 'transference,' nor is there impressive evidence that the success of treatment depends wholly on the extent to which the nature of such a relationship can be laid bare and the emotions linked with it given free expression."

They note the improvement that often occurs after three to six months of such simple psychotherapy, but feel that "the psychiatrist should not deceive himself by attributing the improvement to the therapeutic procedure alone: The acute exacerbations that occur in the course of neuroses have a natural tendency to improve. In most cases, one has merely helped this process of recovery on its way." Later they state, "As with simpler psychotherapy, so with psychoanalysis, many neurotic patients improve, but cures are rare. There is certainly no evidence that the patient with a severe neurosis has been helped more and his improvement lasts longer following three years of analysis than if he had been under the less disturbing and exacting attentions of a wise and sympathetic psychiatrist of any other school. In fact what evidence there is tends to suggest the contrary. It is the most probable conclusion that any success that can be attributed to psychotherapy, after making allowances for the tendency to spontaneous improvement or recovery in the neuroses, is due to the personality of the therapist rather than the theories of psychopathology he holds."

Mayer-Gross et al. feel, however, that psychoanalysis sometimes achieves results "which seem at first sight to be spectacular." They

remark in this connection, "The outlook of the artist and intellectual of our time is so often colored by cynicism, despair, and a preoccupation with the evil and sordid in human nature that his adjustment in life tends to be a precarious one. Not infrequently he turns to the psychoanalyst to explain and alleviate his unhappiness. Jung is probably right in saying that many such people are really groping for some system of religious belief which will provide them with a source of strength and render their lives meaningful. Psychoanalysis in explaining religion, art, politics, social phenomena, literature, sport, as well as mental illness as forms of sublimation of the conflicts generated during the period of infantile attachment to the parents does in fact seem to provide an all-embracing philosophy of life. Given the opportunity of two centuries of research one of its exponents even hopes to discover and eliminate the causes of war by psychological means. There is little doubt that Freudian analysis will do for some of these patients what religious conversion will do for others."

They conclude the section on the individual psychotherapy of neurosis by stating, "we must give what help we can to cure the patient with a neurosis and this will, in the present state of our knowledge, often take the form of psychotherapy together with enlistment of the aid of his relatives and friends in his re-education and the ordering of his life. But it cannot be claimed that we know how to cure neurotics; no specific treatment is known, and certainly no psychological treatment, that can claim successes as striking as those sometimes achieved by pre-frontal leucotomy in severe chronic anxiety and obsessional states."

The authors find value in the group therapy of neurotics, whether it be in the form of explanatory lectures, interpretation of group situations, psychodrama, or therapeutic community work, combined with, in mental hospitals and institutions, lively social activities.

PHYSICAL TREATMENTS IN BRITAIN

By and large, the multidimensionally oriented psychiatrist finds no objection to the use of physical methods of treatment, providing he is convinced from knowledge and previous experience that the measures he employs are safe, ethical, and effective. Thus, in psychotherapy, hypnotics, sedatives, stimulants, and abreagents are used when and where they are indicated. An initial enthusiasm for the more dramatic methods of treatment, such as abreaction,

usually becomes supplanted in the psychiatrist's mind by a more objective and realistic appraisal of the value of these various methods; abreaction, for instance, is very effective if its use is confined to certain specific types of neurosis. Many American psychiatrists will be aware that the British have a predilection for the trial of amphetamines in endogenous depressives and dysrhythmic behavior disorders as well as in enuresis and bulimia, a view which is in line with contemporary British feeling on the value of drug-supplemented psychotherapy. At the University of Durham, where he held the chair in psychological medicine from 1948 to 1955, Professor Alexander Kennedy insisted that every physician working in his department should learn the techniques of hypnosis; he believed that much was to be learned from it, pointing out that it had been used by such great pioneers as Charcot and Freud; the author feels that he was right, and that in Kennedy's department the medical staff learned a good deal from their attempts with hypnosis.

In Britain today, most psychiatrists feel that psychoses are qualitatively different from neuroses and more different than can be explained by any psychological mechanism. This point of view has been expounded in detail by Eysenck[32] and supported by some recent work by Trouton and Maxwell.[33] The normal:neurotic dimension and the normal:psychotic dimension are conceived as being orthogonally rotated. However, this qualitative difference does not imply pessimism or despair; it simply means that the British psychiatrist feels very doubtful regarding the application, to psychoses as well, of hypotheses that have been used to explain neuroses.

SCHIZOPHRENIA AND INSULIN COMA THERAPY

In schizophrenia, it is held that hereditary factors play a predominant role although other constitutional factors (mental and physical), endocrine, metabolic and central nervous system anomalies also play a part. The precipitation of this illness by physical illness and childbirth is recognized, as well as the similarity of some symptomatic psychoses to schizophrenia. The role of psychological factors in precipitating schizophrenia is accepted with some reserve, for it is felt that many of the "precipitants" are in fact the first signs of the psychosis, and it is pointed out that there has been no increase during times of general stress, such as the

first World War. Mayer-Gross et al. say "in short, psychological factors in spite of a widespread belief in their influence, do not frequently precipitate a schizophrenic illness or attack. The psychological situation has, however, considerable effect on the established schizophrenic illness." In Great Britain, the various theories of the psychopathological causation of schizophrenia are found ultimately unsatisfactory, although of not inconsiderable interest. A recent paper by Parfitt[34] emphasizes the neurological and organic aspects of the disease, and the term "genetic encephalopathy" is proposed. Again from Mayer-Gross, "if schizophrenia is based on an organic disorder it seems unlikely that its symptoms should be explained by psychological means only. One can go further. It is demanding too much to hope to find one fundamental psychological disturbance underlying all symptoms, especially if there is doubt whether our present concept of schizophrenia does not comprise several diseases."

With regard to the treatment of schizophrenia, these authors say:

"If the patient is seen by a doctor within two years from the manifestation of the first symptom and if the diagnosis of schizophrenia is established it is nowadays a gross error not to press for his admission to a special unit or hospital where he can receive physical treatment. Even if the diagnosis is doubtful, he should come under psychiatric observation in order to clear the issue and to begin insulin coma therapy, once there are sure grounds for doing so. Prolonged psychotherapy, even in mild cases, can no longer be justified. Psychoanalysis is indeed contraindicated in any stage or type of schizophrenia; to apply it, is, as Freud himself commented, to L. Binswanger, a professional error. This statement has been supported by many critical workers in this field; but it has not prevented others from applying an analytic procedure..."

They go on to say, "Experiments in analytical therapy were permissable as long as no physical method of treatment existed. Schilder in fact gave as his reason for employing them the lack of any suitable physical therapy. For the early schizophrenic matters are now changed and psychoanalysis can only now be justified as a research procedure in the arrested case with schizophrenic defects." As Lord Moran said at the Harveian dinner of the Royal College of Physicians in 1945, "The physician of today

is twice as well equipped in the war with disease as he was when I was a student. And the physician who knows what is wrong with the patient and has an effective remedy in his hands can cut the cackle. He has no need of it." Regarding insulin coma therapy, Sargant and Slater—from whom the author has borrowed the Moran quotation—remark, "Once tried, its results were, in individual patients, so surprisingly favorable that its use spread widely and quickly. In the International Congress of 1938 reports were presented of its trial in most of the civilized countries of the world; nearly all of them were favourable. Its value as the best available treatment of early schizophrenia was generally accepted at the International Congress of Psychiatry in Paris in 1950... At the present time facilities for insulin treatment are provided at all of the progressive mental hospitals in Britain, and few but chronic patients fail to receive the treatment at some time. There are, however, variations in practice from centre to centre. The principal fault in modern hospital practice is not to give the treatment early enough and sometimes to lose valuable time by trying treatment with electro-shock first."

Doubts as to the modus operandi and efficacy of insulin coma therapy were expressed by Bourne[35] recently, in an article in the *Lancet,* entitled provocatively, "The Insulin Myth." This produced a spate of correspondence; but the bulk of opinion at that time seemed still to favor the use of insulin in the present state of our knowledge. Insulin coma therapy in schizophrenia should be regarded, however, as only one aspect of the general approach to the problem made by Rees and others and referred to earlier in this paper.

MODIFIED INSULIN THERAPY

In most mental hospitals in Britain, patients are physically built up where necessary by modified or subcoma insulin therapy, which seems to be very effective in some cases. The method derives from Weir Mitchell's[36] treatment of neurotics after the American Civil War, and is often combined in England with abreaction or electric-shock therapy. Sargant and Slater aptly quote Weir Mitchell's own words: "If I succeed in first altering the moral atmosphere which has been to the patient like the very breathing of evil, and if I can add largely to the weight and fill the vessels with red blood, I am usually sure of giving relief to a host of aches and pains

and various disabilities. If I fail it is because I fail in these very points, or else because I have overlooked or undervalued some serious organic tissue change."

ELECTRIC CONVULSIVE THERAPY

In regard to convulsion therapy, Sargant and Slater may be quoted again:

"Even coroners' juries realise that suicide is a risk of mental disorder. What is less frequently realised is that mental patients do not commit suicide because of some mysterious law of nature but as a general rule simply because they are so miserable they would rather be dead. There are few patients suffering from organic diseases, even an incurable cancer, who get to feel as bad as that. We must account the degree of suffering that can be caused by mental illness as the greatest of all the ills that man is heir to. Yet because the sight of the suffering is so familiar to us, because so often so little could be done, we grew to accept it as inevitable. Even after the shock therapies had been introduced, and convulsive treatment had shown its power to influence depression, a niggling balance of pro's and con's was drawn and patients were denied treatment for the risk of a pain in the back."

They go on to state, "the days of over-caution are now passed, and the dangers are in the opposite direction. The psychiatric revolution which has occurred with the development of physical treatments and the therapeutic enthusiasm inspired by their number and variety, has itself provided opportunities for new forms of tragedy. We are now called upon to realise the convulsive therapy which can bring peace of mind to the hopeless and distracted patient when correctly employed can also be a weapon of terror when unskillfully, unintelligently, or unimaginatively employed..." In schizophrenia, ECT is used in Britain mainly in the management of such syndromes as catatonic excitement or stupor, and is employed as an adjunct to insulin coma therapy. The dangers of hammering away at patients with repeated convulsions, if no worth-while benefits are obtained with the first few fits are recognized, and it is believed that long series of convulsions can produce an even greater degree of deterioration than exists already. A satisfactory, though too short, remission with ECT is used by some as a criterion for estimating the value of a proposed pre-frontal leucotomy.

Apart from schizophrenia, ECT is extensively used in the treatment of psychotic depressions, many of which in later life, masquerade in neurasthenic, hysterical, obsessional, and hypochondriacal disguises which may deceive the unwary. If these "neurotic" pictures really conceal—as they often do—an underlying endogenous depression, impressive results are usually obtained with ECT combined with a firm attitude of positive reassurance. To talk in terms of the doctor-patient relationship, and of the need of the patient to introspect and discuss his interpersonal difficulties when in this state, would seem to the average British psychiatrist to be at best superfluous, and at worst cruel, unnecessary and a waste of time. This is especially true in involutional melancholiacs in which remissions as high as 85 per cent have been reported. In this connection Mayer-Gross et al. remark, "Once the diagnosis [of involutional melancholia] can be confidently made, the treatment should be begun—that is to say providing there are no overriding contraindications." By contraindications, they would probably mean such conditions as a recent coronary thrombosis, active rheumatic carditis, severe liver, kidney, or respiratory disease, and so on. However, it is being increasingly recognized that treatment properly administered with relaxant and adequate oxygenation is a very safe procedure indeed, and seldom imperils life in the way that suicide and starvation can imperil it in depressives.

ECT is also used sometimes to remove obstinate hysterical symptoms or to mobilize a much-imprisoned obsessional; its use in depersonalization and hypochondriasis where there is no affective component, is not usually strikingly successful. Sometimes in Britain it is used in "psychosomatic" illnesses and its use has been seen with a measure of success in skin cases, migrainous patients, asthmatics, and so on; in these cases, however, there was usually some convincing evidence of a depressive factor operating. It is said that a remission can be produced with ECT in an acute episode of ulcerative colitis, but the author has had no personal experience of this. Certainly, before the importance of fluid and electrolyte balance was realized and before powerful tranquilizers became available, ECT was sometimes of great value in the nursing care and management of acute subacute deliria, where it could transform an impossible nursing problem into a comparatively tractable case.

OTHER PHYSICAL TREATMENTS

With ECT and tranquilizers, hydrotherapy has practically disappeared in Great Britain, and the author has never seen it used in any hospital in which he has had experience. Continuous sleep therapy, too, is only occasionally employed, usually in severe anxiety states; but there is not much faith in it at present; the risks and complications seem to outweigh the advantages. Diet, vitamins, and endocrine supplements are administered rather freely; and, in alcoholics, antabuse is generally employed, or alternatively, some other form of negative conditioning is established with emetine or apomorphine injections. However, the general problem of alcoholism is not nearly so great as it is in America. Treatment of epileptics is often left in the hands of the psychiatrists, especially if the epileptics happen to be of the temporal lobe variety, a condition which is not infrequently associated with psychotic pictures. After careful trial of the appropriate antiepileptic drugs—and it is felt by many that sulphonal, though extremely toxic, is one of the most effective—removal of the tip of the temporal lobe is occasionally carried out.[37] About half the cases operated on are improved. There is much interest in geriatric psychiatry and the problem of the pre-senile dementias; Roth[38] and others have published extensively in this field.

Finally, one should say something about psychosurgery. It seems to the author interesting that the operation, which is often referred to as prefrontal lobotomy in America is termed leucotomy in Britain, and it may be that the use of these two terms reflects different attitudes toward the procedure in the two countries. In Britain, leucotomy is a perfectly valid, ethical and justifiable procedure in the present state of our knowledge—to be embarked upon, however, only after careful thought and mature deliberation and after other less drastic methods have been tried and found wanting. Patients who are to be leucotomized are usually reviewed in detail at a psychiatric case conference where the opinions of several senior psychiatrists are available; the consent of the relatives and friends—and if possible, the patient's consent, too—is obtained before the operation is performed. To the British psychiatrist today, leucotomy is a fairly precise procedure, involving considerable neurosurgical skill, in which specific zones of frontothalamic fibers are sectioned—usually, at the present time,

the lower medial quadrants of the frontal lobes. Thus, the topectomies, cingulectomies, orbital undercuttings, and so on, of earlier years, seem to have been abandoned in favor of a return to more discriminating techniques of the standard operation. Patients submitted to leucotomy are carefully selected, and the operation is not postponed overlong—until it is a last ditch resort years after all else has failed.

In every case, intensive postoperative rehabilitation is felt to be extremely important. By and large the patients who respond best to leucotomy are those with good pre-morbid personalities, whose personalities have been preserved well through their illnesses, and who show emotional tension during their illnesses. Most often, these patients are obsessionals with intractable tension states, depressives, and some hypochondriacs and paraphrenics. In obsessives, it is felt that leucotomy probably should not be postponed longer than four years from the onset of the illness, though the operation is seldom done before the age of 30. This policy may be changed in the future, however, for a recent paper by Pollett[39] suggests that the ultimate outlook for non-leucotomized obsessionals is by no means so bad as had originally been feared.

Some of the most recent English views on leucotomy appeared in an annotation in the *British Medical Journal* of September 29, 1956, in which a series of patients subjected to the operation were reported on by Elithorn and Slater.[40] The views that have just been expressed are amplified and the reviewer remarks:

"A preference for an empirical rather than a theoretical approach is traditionally supposed to mark the British character and there are those who would argue that in psychiatry it is a preference that bears fruit. In this country [Great Britain] psychiatrists probably concern themselves less with philosophical issues than do their colleagues overseas. One result of this has been the greater development and application of physical therapies than elsewhere and the most radical of these, leucotomy, must by now have been performed about 15,000 times in Great Britain. While for many years the correspondence columns of this and other journals have contained discussions on the ethical pro's and con's of the operation, general practitioners and psychiatrists have gone on steadily recommending it for suitable patients simply because it so often helps them when all else has failed..." When it is performed,

Elithorn and Slater's article shows that many patients are grateful rather than critical afterward. Further, the annotation to their paper states: "... when the modified operation (which leaves fewer undesirable post-operative sequelae) comes more into general use, many of the remaining objections to this method of relieving this intolerable mental suffering will stop. Elithorn and Slater do well to state 'surely the fact that leucotomy is a crude therapeutic weapon and that unnecessary and unwanted changes are often produced by it should not blind us to the observation that occasionally it may produce effects which are wholly beneficial.'"

These views may be contrasted with some early work on the subject. Stafford-Clarke[5] cites the 1948 analysis, by the British Board of Control, of 1,000 consecutive leucotomies in which 348 men and 652 women were studied. It was found that 25 per cent of the patients had improved enough to be discharged from hospital; and that 36 per cent, while still needing to be kept in hospitals, were regarded as subsequently improved, both from the point of view of their own wellbeing, and the ease with which they could be nursed and cared for. A total of 5 per cent of the patients died as a result of the operation. Five hundred and ninety-nine of the 1,000 patients had been diagnosed as schizophrenic; when the other groups were studied separately, it was found that the results in manic-depressives, involutional depressives, and obsessional patients were proportionately better than those of the series as a whole. All in the series had been selected as otherwise incurable after being in hospitals for many years. There is little doubt that a similar series today would yield even more impressive results, especially if adherence to known criteria were strictly practised.

Conclusion

In summarizing, the author would say: The British psychiatrist today feels that sound factual knowledge, accurate diagnosis, and adequate treatment—even though this be in part empirical at the present time—combined with humanity, kindness, common sense, and a nonrestrictive hospital atmosphere is the most effective way to approach the psychiatric patient. With these methods, he feels,

one can most nearly attain Trudeau's ideal, "to cure sometimes, to relieve often, to comfort always."

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HOUSEHOLD APPLIANCES AND THE SYMBOLIC PROCESS*

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> Everything points to the conclusion that the child passes through an animistic period in the apprehension of reality, in which every object appears to him to be endowed with life, and in which he seeks to find again in every object his own organs and their activities.
>
> —Ferenczi[1]

Automation, a contraction of automatic production, is becoming the byword of the mid-twentieth century. Man is apparently succeeding in discovering, externalizing, and reproducing his inner silent physiologic and anatomic self. As a result it is becoming increasingly difficult to differentiate the living from the non-living; to delineate man from some of his inanimate synthetizations. In everyday communication, when it is said a Ford is powerful, there is some doubt whether one is referring to a business magnate or his product. Today, there is concern that man may become a slave to the machine he has created; that, in truth, automation will cause him to become an automaton himself. Such expressions are derivatives of unconscious fears that the differentiation between the self and the not-self, and between what is internal and external, will become increasingly difficult. This would put an added strain on the process of reality-testing.

That cultural patterns and developments affect the psychic apparatus, the symbolic process in particular, is now common knowledge. For instance, the infant is introduced to the benefits and vagaries of household appliances almost as soon as he becomes aware of his parents, his siblings, and his own body. As he starts to crawl and move about, his first warnings and prohibitions, even earlier than those about auto-erotic activities, are against touching such things as the stove and electrical outlets.

In a recent psychiatric case seminar, an instance was revealed of a mother who kept an electric egg beater running outside her child's bedroom supposedly to help him overcome his fear of noises. Later in life this child came to analytic treatment because

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of extreme passivity. A study of his fantasies revealed a conceptualization of the vagina with internal whirling blades, the modern equivalent or mechanical counterpart of the "vagina dentata."

Household appliances hold many realistic dangers, as well as gratifications, for the child, as well as for the adult, and may thereby become objects onto which affects may be readily displaced. In psychopathological states, as Kubie[2] has brought out, the symbol and its concept no longer are separated, but may overlap to various degrees. In normal development, the use of household appliances provides comfort, as well as a sense of mastery over the environment. For girls, they may be aids in identification with the mother in her household work, and nurturing duties. Thus, whole toy kitchens in miniature can be purchased so that the daughter may act out in play what the mother performs.

However, in unconscious fantasies and dream life, these appliances, as noted, readily lend themselves to inappropriate affect. In adult life, in depressive and schizophrenic states, suicides and macabre mutilations are performed in the kitchen; and death by gas asphyxiation is one of the most common types of suicide.

More grotesquely, cases are reported where the individual puts his head into the oven. The obsessive-compulsive neurotic fears sharp instruments and constantly worries about the gas heater being turned off or the toaster being disconnected. In the hysterical individual, the appliances often symbolize objects of both an oral and genital nature, wherever there can be substitute gratification and punishment. The hysterical patient may be fascinated with gadgetry and at the same time be worried about the safety of such automatic controls as timers, defrosters, and thermostats, as are built into the appliances.

All modes of energy are transformed, neutralized, and regulated in the service of making life easier and supposedly more pleasureful. Very often the hope is that new devices will be both labor-saving and in the long run "pay for themselves." Abetting the economic factor, is the condensation of many processes and functions in the same unit. So there are radio-television-phonograph combinations; clock-radios, coffee-making radios, units that heat and humidify in the winter and do the opposite in the summer. The multipurpose appliance, par excellence, is the stove. For instance, it cooks on its surface, broils, bakes, and grills in the inside, and at the same time may heat and give light to the

room. This is aside from such things as timers, thermostats, clocks, radios, and bells. The stove may be supplied by one, two, or even three different sources of energy, separately or in combination. Here is an excellent object-representation of condensation and overdetermination. If there is dysfunction, the stove may explode, cause injury to life and property, become disfigured, discharge dangerous fumes and odors. Other breakdowns of appliances, often without physical dangers, have, nonetheless, become major household disturbances. Appropriately enough, the comic in his skit has captured the disintegrative potential in the household wherein faulty wiring causes music to come from the refrigerator, or the radio freezes over.

Clinical Material

In the treatment of certain neurotics, but most often in borderline cases, one is impressed with the way appliances are woven into the matrix of fantasy life. Kitchen and household items very often symbolize conflicts for the woman about identification with femininity and motherhood. Competitive factors with the mother-image frequently make the kitchen strictly mother's domain; and to be in the kitchen, means to usurp mother's position. On a deeper level (that of James Thurber's now classic cartoon) the house and mother are fused.

A woman in her early 30's came for analysis because of difficulties in interpersonal relations. Her marriage of five years had ended in divorce. Now, male acquaintances seemed to be frightened away, even though (or because) she frequently fed them and lavished expensive gifts on them. She was fearful of driving her car—having the feeling that oncoming cars would force her off the road. Her history revealed catastrophic circumstances in her early life.

Her mother had died following a goiter operation when the patient was five. Eight months later, her father was killed in an accident on his farm. Thereafter, the patient was brought up in several foster homes, supported by public welfare. She made a submissive, passive adjustment to the women of these homes and managed to get through school and college on scholarships. Thereafter she went into professional life and became fairly successful at her chosen work. Sexually, she "had been" with several men, she had orgasms, and knew of no conscious fears in this regard.

However, she revealed persistent fears about the process of childbirth, which she visualized as a gory mess. She had heard weird stories in her foster homes about what a woman went through and about the complications that might occur.

The early hours of treatment were characterized by long periods of silence and the patient's feelings of nausea. Her first dream was as follows. "She was at a typewriter. She had a secret which she wrote out. She looked at the paper, then tore it up. No one would know her secret."

There were no associations to the dream—and she had no idea what the secret could be. Treatment was temporarily interrupted at this point by the therapist's vacation. On his return the patient brought the following dream at the first hour of the resumed treatment.

"I was in my apartment. I went to the refrigerator looking for food. I found that it had been turned around, the door facing the back wall and hence unavailable. I was deeply disappointed. I then turned to the stove. I touched a match to the burner. There was an immediate explosion. The stove became charred, gas emanated from it, and a stream of purple liquid seeped out from it. I was terrified and awoke."

The associations were as follows: At one of the foster homes, she had been warned repeatedly that only the foster mother could light the stove, lest it explode in somebody's face, or set the house afire. She is very sensitive to gas fumes; they make her violently ill; she often has to leave the house when there are odors. About the purple fluid, she could make no associations. She recalled that it was purple but didn't know what it could have to do with a stove. She was asked if she knew of any chemical or medicine of that color. She then recalled that five years before she had been treated for a vaginal discharge with the use of purple tablets which were dissolved in the vagina.

With this added information, something of her latent thoughts could be pieced together. The stove represented her ano-genital region, not to be touched digitally. This area might become hot, explode, exude gas and colored liquids. Her secret, then, was her infantile masturbatory activity (she had discovered her hidden genitals). During the therapist's absence she was deprived of access to food (the unavailable refrigerator), and her present masturbatory activities increased.

A reconstruction of her problem became possible. Her unconscious fear was that through masturbation, she had injured her genital and reproductive organs and had thus impaired her ability to have children. The burner on the stove represented her exterior clitoral region, which was touched and heated. This caused an explosion which charred the stove's exterior (anal contamination) and also destroyed the inside of the oven (the womb). She feared that her chronic masturbatory activity had led to her vaginal discharge and to the need for the purple medication. These feelings of self-injury and mutilation were also related to the deaths of her parents, especially that of her mother. The goiter operation was visualized by her as a mutilative procedure, connected with oral impregnation fantasies. Her nausea and silence in the early hours of therapy proved to be on the basis of these oral fantasies.

Another example of this type of primitive symbolization was seen in a 36-year-old married woman with two small sons. She came for treatment because of acute episodes of anxiety which followed the second childbirth. She became oversolicitious of both children, and worried about their health, physical and mental. She was likewise very apprehensive about her own health and often envisaged herself dying without proper medical care. Sexually, she was completely frigid—with neither clitoral nor vaginal sensations during intercourse. There had been orgasms—in dreams in which she would watch herself in a mirror. But the frigidity was not her presenting complaint.

She was the only child of doting parents. She described her mother as pushing her out of the kitchen. Her mother had repeatedly told her that it was bad enough that one of them had to be burdened with household chores. Any attempts by the daughter at domesticity were belittled. The mother always pointed out how inept the daughter was at these things. After marriage, in her own home, the patient became uncomfortable in the kitchen. At this time, "knowing" her daughter's ineptness, the mother continued to warn her about household, and especially about kitchen, dangers. She feared that, during a depressive episode, the patient might harm herself with a knife or might "lose control" and open all the gas jets.

During the patient's early treatment hours, there were recurrent dreams about cooking and baking. In one, she was cooking a large

turkey in her oven to bring to the therapist. Many sessions were devoted to the automatic garbage disposer which grinds up and liquefies garbage. A screw had fallen into the mechanism and had broken the apparatus. This caused her great anxiety. She became furious at her husband, and at the repair man, as well as at the bill for repairs. She related this affair to the treatment; she felt that she was being treated like garbage, that she was being ground up instead of being put back together.

At another time, intense erotization of the transference occurred. The therapist became idealized as the superpotent individual who could cure her of her anxieties and with whom she could surely achieve an orgasm. As the analysis progressed, it became apparent that she was covering her own phallic strivings.

She felt her mother didn't want a girl, or she would have encouraged her work in the kitchen. To be accepted by her mother, one had to be a boy. She was jealous of the analyst; her passion for him covered up intense castrative feelings. At the point in the analysis when these feelings began to emerge, she reported the following dream.

"I was in my living room, my two sons were there. I was using the vacuum cleaner on the rugs. It suddenly became very powerful —was vibrating and sucking in the rug and other objects. I tried to turn it off and kept fumbling with the switch. My husband came in, and I was embarrassed that I could not work the machine in front of him. I then pulled out the plug. This didn't help either —it kept vibrating without being plugged into the electrical outlet. I got a feeling of utter helplessness."

The associations were as follows: "I usually love to vacuum. I have a Hoover, the upright kind. I hate those round squat affairs where the pipes dangle around your legs. I suppose I hate to reveal my ineptness in front of my husband. He has to put up with a lot. I feel so guilty—at the end of the month when I have to pay the bills, especially for treatment. It makes me feel so extravagant."

The overdetermination in this dream is quite obvious. In the appliance there is a condensation of oral, anal, and bisexual genital elements. In addition there is an orgastic effect in the vibratory sensations. The patient frequently spoke of having these "vibrations" while on the couch. There is also evidence of omnipotent desires in the operations of the appliance, without its being

connected. This expressed her wish to be independent of her ambivalently-held objects.

Of special interest is the sucking activity of the apparatus. It is depicted as very intense, taking in both the dirt and the rug to be cleaned. It represents a condensation of fantasies pertaining to the oral as well as the vaginal and anal regions. During periods of anxiety, the patient feared being near her mother or parental substitutes. She felt at these times that she was particularly vulnerable to being "sucked into" her mother. These feelings were conscious counterparts of other desires to make connections by sucking on the objects around her. These would be nursing and fellatio, as well as vaginal and anal incorporative fantasies.

This dream is similar in content and meaning to those cited by Ostow[3] as demonstrating "linkage" fantasies and representations. Here, an instinctual need to be reunited with the mother, or later with a substitute object, is expressed by representations such as pipes, electric cords, tubes, clasped hands, and connected waterways. In these dreams, appliances, automobiles, and other mechanical devices also appear abundantly in the manifest content.

The last two or three generations of men have invented and exposed themselves and their offspring to a myriad of mechanizations in the home. A shift has taken place from religious and related animisms to technocratic ones. Man now creates machines as he formerly created deities. Recalling Ferenczi's quotation, one can speculate about the effects on the infant's mental apparatus of perceiving in the inventions around him the actualization of his own animistic projections. Feelings of omnipotence may be enhanced. The distinction between self and object representations may be made more difficult. In the child this may lead to phobic reactions relative to these moving, sucking, whirling, sound-producing machines. In the adult, annoyance or the opposite, fascination, with "mechanized living," may reflect the persistence of these fears in latent form. In certain psychopathological states and in dreams, feelings about appliances may again reach phobic proportions.

Summary

Clinical material is cited which demonstrates the use of household appliances as representations in the manifest content of dreams. Because of their automation and multiplicity of purpose,

appliances lend themselves to the overdetermination needed in the symbolic process of certain patients. In this regard, "linkage symbols" are prominent. Some possible effects on the infant of exposure to the machines around him are discussed.

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Communication—

FETISHISM: AN ADLERIAN INTERPRETATION

Comments on Nagler's Paper on Fetishism: A Review and Case Study

BY HEINZ L. ANSBACHER, Ph.D.

Dr. Simon H. Nagler, in his review of the literature and case study of fetishism (Nagler, this QUARTERLY, 31:713, 1957), finds that "present-day psychoanalytic thinking is still mechanistic-instinctivistic in its traditional manner" (Nagler, p. 724), in contrast to which he contends that fetishism "arises out of life conditions that result in the evolution of the total human personality as an adaptational system with its distinct and individual life pattern" (p. 717).

It was exactly such general divergence in theory—not limited to fetishism—which led Alfred Adler to his separation from Freud in 1911. Nagler does not mention Adler, and so one may assume that he does not know him. At the same time, Nagler arrives at conclusions regarding fetishism which are practically point for point a restatement of Adler's position on this particular topic. Therefore, Nagler's study can be taken as an independent confirmation of various Adlerian hypotheses, as there will be an attempt to show briefly in the following. All Adler references with one exception, *The Science of Living,* are to the recently published selections from his works: *The Individual Psychology of Alfred Adler* (Basic Books. New York. 1956).

1. *Style of Life.* According to Adler, the attitude of every individual toward sex and marriage is "one of the expressions of his style of life: we can understand it if we understand the whole individual, not otherwise" (Adler, p. 434). In contrast to certain "doctors and psychologists who believe that the development of sexuality is the basis for the development of the whole mind and psyche," Adler asserts a reversal of the order, namely, that "sexuality is dependent upon the personality—the style of life" (*The Science of Living.* P. 254. By Alfred Adler. Greenberg. New York. 1929). "Masturbation, premature ejaculation, impotence, and perversion all show a halting style of life, consequent on a fear of inadequacy in the approach to the other sex" (Adler, *Individual*

Psychology. P. 279). Adler uses "style of life" synonymously and interchangeably with "plan of life" and *"life pattern"* (p. 173).

Nagler is in full agreement when he states: "Fetishism is not merely a narrow aspect of psychosexual development, and is not merely a sexual practice, but is a segment of a way of living 'motivated by a special kind of consciousness'" (Nagler, this QUARTERLY, 31:4, October 1957, p. 737). Later on Nagler substitutes for way of living the term *"life-pattern"* (p. 739).

2. *Low self-esteem and negative attitude toward one's sexual role.* One of the characteristics of the life style of the sexual pervert is, in Adler's view, a low self-esteem. "The common factors in sexual perversion (homosexuality, sadism, masochism, masturbation, fetishism) can be summarized as follows: ... The perversion indicates a more or less deep-seated revolt against the normal *sexual* role, and is at the same time a purposeful, although unconscious, device to enhance a *lowered self-esteem.* Inclinations toward perversion in men are compensatory tendencies to alleviate a feeling of inferiority in the face of the overrated power of women" (Adler, p. 424).

Nagler bears out Adler with these words: "What is common to the triad homosexuality, fetishism, and transvestism ... is the fear of the *male social role* in its entirety in the face of an overwhelming sense of inadequacy and a *low self-esteem"* (Nagler, p. 737).

3. *Wanting to be a "real man."* What are the dynamics resulting from such a sense of inadequacy? Says Adler: "The neurotic purpose is the enhancement of the self-esteem, for which the simplest formula can be recognized in the exaggerated 'masculine protest.' This formula, 'I want to be *a real man,*' is the guiding fiction, the 'fundamental apperception' in every neurosis, where it demands realization to a higher degree than in the normal psyche. The libido, the sex drive, and the inclination toward perversion, irrespective of their origins, become subordinated to this guiding thought" (Adler, p. 108).

Nagler's patient himself confirms this dynamic. The patient is quoted as saying: "I don't want to compete with a fellow for a girl. Why would she have me when she can have a regular man" (Nagler, p. 735)? "I try to act like a man but I am not" (p. 736).

And Nagler notes that the patient was on one occasion very eager to impress a fellow worker that he was *a "real man"* (p. 736).

4. *Passivity.* In the fetishist, the masculine protest takes a passive form. "Cases of sexual perversion," says Adler, "may, from the point of view of activity, be found all the way from the lowest to the highest degree of activity. At the low extreme we find masturbation or fetishism, at the high extreme possibly the lust murder, both characterized since childhood by a corresponding radius of action and inadequate social interest" (Adler, pp. 165-166). Where attempts to break through along masculine sidelines fail, the patient is forced further "into the *feminine role*, apathy, anxiety, and mental, physical, and sexual insufficiency" (p. 50).

Nagler suggests similarly that "the fetishist is a passive, dependent individual of extremely low self-esteem, who seeks slavishly in fantasy to win favor and acceptance. Feeling inadequate to the full role of the male, he serves the woman adoringly, religiously or slavishly, to gain her love and her tolerance for his inadequate performance. In the case of the homosexual fetishist, *he serves the man* to gain his own acceptance as a male and thus is permitted to salvage his self-esteem" (Nagler, p. 739).

The case history itself, one of foot fetishism, lends itself most readily to Adlerian interpretation. All the components of Adler's theory of the neuroses are present. Nagler's patient, as an infant, not only suffered from physical inferiority, but was also a very pampered and at the time unwanted child. As an only child, he had little opportunity to develop his social interest, both his parents being very self-centered and incompatible, besides. With a beautiful mother who customarily paraded nude in front of her son, "even at this late date" (Nagler, p. 733), yet who administered all the physical punishment to him to the extent that she would even kick him in her anger (p. 730), we can well understand that the patient developed a life style which assured him psychological distance from the opposite sex. In Adler's words, "Every perversion is the expression of an increased psychological distance from the opposite sex" (Adler, p. 424). This distance seeking he later also called "exclusion tendency."

Adler's is, however, not a deterministic psychology. Even with all these factors the patient was not actually committed toward fetishism. To resort to it was in the end his own doing. And so

we may conclude with this quotation from Adler: "This exclusion tendency is not merely an accident; it is a matter of self-training. There can be no sexual perversion without preparation. Only those who have noted this training will understand that sexual perversion is an artificial product. Each person has formed it for himself . . . although he may have been mislead into it by his inherited physical constitution which makes the deviation easier for himself . . . although he may have been misled into it by his presentation gives ample evidence of such preparation and self-training.

Adlerian therapy, of course, consists in getting the patient to understand the error in his life style, to show him that he did not have to make this error, and that he can still correct it through becoming aware of the significance of his manifestations in their larger context, and through developing his assumed innate aptitude for social interest.

SUMMARY

Nagler explained, in contrast to the still prevalent mechanistic-instinctivistic psychoanalytic thinking, that fetishism arises from a distinct individual life pattern. The present paper shows that in doing so Nagler, in fact, offers full support to the Adlerian hypotheses regarding fetishism.

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EDITORIAL COMMENT

IL MEDICO DEL DOLCE FAR NIENTE: REX DO-NOTHING, M.D.

Nothing, sirs, but nothing! To abstain from action is, in some schools of Far Eastern religion, to acquire merit.** To abstain from anything, seems to be—in some of our hospital practice and elsewhere—the modern medical equivalent.

In Dostoevsky's tragic masterpiece, *Crime and Punishment,* Razumihin speaks his mind to Zossimov, the physician:

"'Listen,' he said, 'you're a first-rate fellow, but among your other failings, you're a loose fish, that I know, and a dirty one, too. You are a feeble, nervous wretch, and a mass of whims, you're getting fat and lazy and can't deny yourself anything—and I call that dirty because it leads on straight into the dirt. You've let yourself get so slack that I don't know how it is you are still a good, even a devoted doctor. You—a doctor—sleep on a feather bed and get up at night to your patients! In another three or four years you won't get up for your patients.'"†

Dostoevsky was himself the son of a doctor; he was an epileptic with penetrating insight into his own disorder and into abnormal mental conditions generally. Whether fat and lazy Zossimov is also a product of the author's insight, or of his Oedipal strivings against his father, or is a deservedly bilious portrait of one of his father's colleagues is as may be. Doctors, like men of the law and men of the cloth, have been targets of more or less ill humor from time immemorial. As Billy Bones put it in *Treasure Island,*‡ "Doctors is all slobs."

The purpose of this discussion is to pay heartfelt professional disrespects to some of Billy Bones' slobs—in particular to the slack do-nothing type singled out by Dostoevsky. Let it be pointed out in plain and simple words that this is not an attack on a profession but a criticism of certain members of it, members who

*With suitable respects and acknowledgments to Messrs Bradley and Edgington, the ingenious gentlemen who first turned R into "Rex" for the daily cartoon strip of medical adventure—Rex Morgan, M.D.

**See Rudyard Kipling's novel, *Kim.*

†Feodor Dostoevsky's *Crime and Punishment,* as translated by Constance Garnett. The quotation is from page 187 of the Random House edition.

‡Stevenson, Robert Louis: *Treasure Island.*

have the capacity and industry to go through medical school and internship, and who have gone on to specialization, and who thereafter act as if they need do nothing—but nothing!

Do nothing is a creed that is rationalized in psychiatric circles by misunderstanding and misapplication of the nonauthoritarian and nondirective technique of psychoanalysis, with patients and in circumstances where it is inappropriate. The rationalization is reinforced by listening to much professional talk of nondirective psychotherapy, nondirective group therapy and similar procedures—without adequate understanding of what they are and when they are indicated. It is supported by half-comprehension of reading and of other teaching material, such as the motion picture, *Out of Darkness,* which will be discussed in some detail later. Behind the rationalization, of course, are motivations in insecurity, dependency and passivity.

To go through college and medical school as Mr. Passive Dependent may be natural enough for some young students, particularly if they come from overprotective homes. For the student to emerge into medical practice as Rex Do-Nothing, M.D., with patients of his own now dependent on him, is less to be condoned. Paul Gallico once wrote a modern fairytale of a boy who turned into a cat and was receiving lessons in cat behavior from a lady who had always been a cat. "When in doubt," said the teacher, "wash!" (Any sympathetic observer will note that this is good cat custom.) But the cat is not a passive-dependent creature. The creed of the passive-dependent physician—the "feeble, nervous, wretch," Zossimov, as his loudmouthed student critic saw him—involves nothing even so positive as, "Wash!" Passive, dependent and afraid—and unfortunately supplied with plausible rationalization for his nihilism—his solution is, "Do nothing, nothing at all."

Virtue in nothingness in the Western World has fewer religious than philosophical connotations. The nothingness of Jean-Paul Sartre's famous *L'Être et le Néant** seems to have penetrated into medical practice by some sort of osmosis, not as Existential Analysis** or anything else positive, but as purely philosophical nonentity. Nothing is a virtue, or maybe virtue is a nothing: *Psychiatrie á Sartre aux Hôpitaux du Néant.*

*In English translation as *Being and Nothingness.* Philosophical Library. New York. 1956.

**See Eugen Kahn's Appraisal of existential analysis. PSYCHIAT. QUART., 31:2 and 3, April and July 1957.

Nondirective or nonexistent therapy? One may wonder what is the difference; or, even if there is a difference. Sometimes we see physicians who appear to have been impressed by only one phase of the Oath of Hippocrates: "I will ... abstain from the deleterious."* One assumes that they assume, of course, that doing nothing is not deleterious. Their reason is misapplication of nondirective psychoanalytic technique, which, some seem to assume, warrants doing nothing after the initial psychiatric examination.

This is not to be confused with the beneficial refusal to tamper that follows doing what needs to be done and is part of good medical treatment. "*Je le pansai,*" said Ambroise Paré, "*Dieu le guérit.*" Rendered freely, "I dressed his wounds. God healed him." To put this dictum of the world's first great surgeon into modern psychiatric terms, one administers promptly the indicated treatment and then nature performs the healing.

Indicated treatments may differ, according to the patient's complaint and the physician's proclivities. After Paré discarded the treatment of wounds by boiling oil, he bought a secret formula for dressing them. It included a strained soup of boiled puppies and earthworms, mixed with other "healing" ingredients. It should be recorded that God continued to heal Paré's patients anyway. The modern surgeon will, within limits, exercise his choice between dabbing a minor wound with iodine, slapping on a tincture of organic mercury, or cleansing it and applying a square of sterile gauze and a strip of adhesive plaster. For more serious cases, the surgeon, of course, has his choice of a wide number of generally approved procedures.

So with the immediate treatment of mental disorder. The physician may order shock therapy or a "tranquilizer"; he may administer brief supportive psychotherapy; or he may even start with carefully supervised milieu therapy or occupational therapy, designed to bring the patient into better contact with reality. The point at issue is that he does "something," not "nothing."

The psychiatrist often hears the taunt that his specialty is barely—if even barely—out of the medieval period from which it required centuries for surgery and internal medicine to emerge. Shock treatment, say psychiatry's critics, is the equivalent of the snake pit and the ducking stool; the "tranquilizers" are drug equiv-

*As given by A. N. Foxe in: The oath of Hippocrates. PSYCHIAT. QUART., 19:1, January 1945.

alents of chains; the psychotherapies are modern versions of the spells and incantations of the dark ages. All this amounts to saying that the psychiatrist doesn't know what he is doing; and an impressive case can be made for the indictment. But a rather impressive indictment can be made against the practitioner of any other scientific specialty—except perhaps mathematics. The internist may still use certain medications and prescribe certain diets for which no better justification can be found than empiricism, and for which the rationale, if any, has its origin in magic. The surgeon performs certain procedures for which justification must be sought elsewhere than in science. In other applied sciences from chemistry to astronomy, accumulated knowledge is still far outweighed by what is still to be learned; the theories of 1958 may seem as far outdistanced in 2258 as those of 1658 seem today. We have seen revolutions in the underlying theories of physics and astronomy within our own lifetimes. In our own lifetimes we have also seen the emergence and decline of medical and surgical fads—the pneumonia jacket and indiscriminate tonsillectomies, for instance. Why should we blush at comparable incidents in psychiatry? Or, what is more to the point, why should we humbly accept sweeping criticisms as valid and react to their validity by doing nothing—on the theory that "we don't know what we are doing anyway"?

Medicine and surgery in general followed a long, difficult and discouraging road from medieval darkness to the twentieth century's comparatively high achievements. Consider medicine in general in France a century after Paré. Paré, a truly modern scientist in spite of his superstitiously-derived, boiled-earthworm wound dressing, died in 1590. Less than a century later, in the "splendid century" of Louis XIV—Louis the Great, the Sun King, the man who was the state—the doctor was a tradition-bound character, dedicated less to the fight against disease than the fight against innovation. A commentator on the period remarks that it is difficult to say "who or what the Paris [medical] faculty hated most—chemistry, and chemical medicine, alleged discoveries, surgeons, royal physicians [who were not of the Paris school], apothecaries, each in turn had been fiercely attacked . . ."* The dean of the faculty at midcentury, he adds, "stands self-revealed [by his volu-

*Lewis, W. H.: The Splendid Century. Doubleday Anchor. Garden City, New York. 1957.

minous letters] as a spiteful liar, a dishonest controversialist, and a hater of all mankind..." And Molière, he goes on to say, has conferred on the seventeenth century French medical profession "an inglorious immortality."

Molière at least did the best, or the worst, that his genius allowed. In comedy after comedy, the great playwright poured venom on the physician. Molière's doctors are scoundrels or fools, at the best, educated idiots. A pompous windbag of a physician is persuaded that a sane man is mad and pursues him with a syringe, a "little injection... to open the bowels, to open the bowels."* One might hurry a depressed patient today to the electric shock machine; but today's psychiatrist, one hopes, would first make certain that he really was depressed; Molière's doctor takes a bystander's word for it and then, himself, provides imaginary symptoms.

In another play,** Molière has an ignorant servant impersonate a doctor without being suspected and with complete success until he is unmasked by accident. Again in *Le Malade Imaginaire*,† Molière brings out what he considers to be the professional philosophy of the medical practitioner. M. Diafoirus, the physician, (his name appears to be a play on the French term for diarrhea) is talking, presumably in breach of professional etiquette, to a maidservant; "To speak frankly to you, our profession when near the great has never appeared pleasant to me; and I have always found that it does better for us to remain with the public. The public is easy to deal with; you are responsible for your actions to no one... But what is vexatious with the great, is that, when they fall ill, they absolutely wish their physicians to cure them." Says Toinette in reply: "That is funny! and they are very impertinent to wish you gentlemen to cure them! You are not near them for that; you are there only to receive your fees, and to order them remedies; it is for them to get better, if they can." And M. Diafoirus remarks that that is true. There is an ironical note in that Molière himself played the part of the man who imagined himself ill, became really ill himself, and died following the play's fourth performance; whether a despised doctor attended him is not on record.

*Moliere: *Monsieur de Pourceaugnac.* Translation by Henri Van Laun. Act I, Scene XVI.

**Moliere: *Le Medicin Volant.*

†Moliere: *Le Malade Imaginaire.* Translation by Henri Van Laun. Act II, Scene VI.

A century later in England, Diafoirus' scheme for medical practice was in full vogue. The fashionable physician collected his fee and prescribed—nothing more. This was the century of Thomas Dover, M. B., the inventor of Dover's powder (*pulvis ipecacuanhae et opii*), which is still prescribed and used as a household remedy to this day, known to the general public of his day as the privateer who looted Guayaquil, and known to students of literature of our day as the mariner who rescued the marooned Alexander Selkirk (on whom Defoe modeled Robinson Crusoe) from the island of Juan Fernandez. Dover was a conscientious fellow who prescribed pounds of metallic mercury to patients with abdominal pains (the best remedy for appendicitis before the day of operations), and who could be counted on to bleed almost anybody profusely at almost any time for almost any thing. Some of his contemporaries were less admirable. This was the era of the "coffee house physician." The apothecary was the family "doctor" for minor illnesses; for major ones, he met a physician for consultation at a coffee house. Dover held consultations; but he was also busy with personal attendance on private patients; and he worked himself to exhaustion in fever epidemics. Less scrupulous and more mercenary physicians confined themselves to "coffee house" practice and welcomed epidemics as sources of income. Two of the more famous or fashionable physicians of the day charged their apothecaries "half a guinea for prescriptions written without seeing the patient."*

Such is the early history of Dr. Do-Nothing. In the France of Molière's day, he was ably assisted by Dr. Quack and Dr. Superstition. In the England of the following century, he had the scene pretty much to himself, particularly at the height of coffee house practice. In coffee house doctoring, the medical do-nothing of the eighteenth century reached a previously unattained height of power and prosperity. The nagging worry that is behind these lines concerns whether he may be seeking a haven in the twentieth century as a specialist in psychiatry.

These bitter observations are not intended to suggest that—in revulsion from doing nothing—we greet new patients indiscriminately—the tense and agitated, the deluded and hallucinated, the paranoid, the elated or the depressed—with the full armament-

*Dewhurst, Kenneth: The Quicksilver Doctor. The Life and Times of Thomas Dover, Physician and Adventurer. John Wright and Sons, Ltd. Bristol, Eng. 1957.

arium of hypodermic syringes, electric shocks, drills, cauteries, and leucotomes, plus or minus various kinds of psychotherapy. They are intended to suggest, however, that there is more than a chemical trace of sweet reasonableness in the patient's feeling that he has come to the hospital to be helped—and that he expects active help—as well as in the swelling chorus from friends and relatives: "Do something! Do anything! But do something!"

"Do something! Do anything!" are demands which often have brought results. Those who have grown old in psychiatric harness can remember when the bromides were used to the point of abuse; when so-called total push was applied to suitable and unsuitable patients alike; when metrazol and insulin were sometimes administered despite professional doubts and even contraindications; and, later, when enthusiasts about electric shock and psychosurgery could not shove patients along fast enough toward those procedures. Today, of course, the pressure is for immediate administration of reserpine, chlorpromazine or other "tranquilizers." It is a fortunate development, for, if dangerous side effects are guarded against adequately, the results of this drug administration—when not highly beneficial—are at least reversible.

It is somewhat painful to see public pressure, rather than pure scientific considerations, affecting medical treatment; but let it be noted that there is some medical reason to justify public pressure. We do not have a heal-all, or even a specific—valuable as the new drugs are—for mental illness. Painful or not, the truth seems to be that this is an area where public pressure seems likely to do psychiatry some good, if the resources we now have are to be used to the utmost. Passivity is not only an individual fault, it can become an organizational fault, or the fault of a group as well. One can cite a recent letter sent out by the National Committee Against Mental Illness over the signature of its executive director, Mike Gorman.* Mr. Gorman notes that the National Institute of Mental Health has been "dragging its feet" on the question of training the general practitioner; he thinks it has not lived up to Congressional directives in the way of long-range planning; and he pledges his committee to seek more money from Congress for the Institute's training and research project, and to see that the Institute expends whatever funds it has without any "negativism."

*Communication on developments as the 1958 session of the United States Congress drew toward a close.

If the implication of passivity is justified, pressure is called for; if it is not justified, pressure still may help. At least, nothing should be resented which should stimulate activity for the benefit of the patient, activity either as a profession or individually.

The individual practitioner—even if the astonishing new pharmacotherapy is not a magic heal-all—still has an enormous range of possible methods. They may extend from medication, environmental treatment and psychotherapy to the shock procedures and psychosurgery—in the selected cases where there is still considerable agreement that these more drastic measures are indicated. If the patient and his relatives see that none of these is being tried, although some would at least make the patient more comfortable, there is pressure on the individual practitioner comparable to the pressure that is welcomed when it is exerted on psychiatry as a whole for the benefit of the profession as a whole.

The generalities expressed here should be qualified. Particularly as to hospital practice, it should be noted that in some well-staffed institutions, both public and private, there is every effort to pay attention to the new patient immediately. In such a hospital, something may be done promptly, even if only to give some relief by means of sedation. In the under-staffed hospital, prompt attention is more difficult. But in both types of institution, and in the hundreds that come somewhere between these extremes, as well as in private practice, there are psychiatrists imbued with a doctrine that, however sound in other times and other places, is not suitable in their circumstances. This is, as has already been noted, an extension of the doctrine of nondirective psychotherapy, which is frequently construed to mean that the therapist must be completely passive in his psychotherapy, and is sometimes put into practice to such effect that there is *no* therapy. There cannot, under these circumstances, even be reassurance for the fearful, practical advice for the perplexed, or sedation for the agitated—for any of these procedures would impair the therapist's passivity.

It is submitted, with emphasis, here that this sort of thing has no place in a hospital or in psychiatric office practice. It is derived from highly specialized treatment where it has long been a recognized and legitimate technique in orthodox Freudian psychoanalysis. The theory is discussed with acumen and at length

by Melitta Schmideberg in a paper in this issue of this QUARTERLY.* Dr. Schmideberg makes the point that "passivity" is not always justified, to put the matter most mildly, even in protracted psychoanalysis of a neurosis. "After all," she says, "if the patient could work out things for himself, what would he need the therapist for? . . . On the whole it is generally agreed that self-analysis is of little therapeutic value. But what is the difference between self-analysis and analysis with a silent analyst in the background, except for the fees paid?"

Suppose, however, that one considers the institutional situation. To paraphrase Dr. Schmideberg: If the patient could work out things for himself, he would not be in an institution. And what, besides curtailment of liberty, confusion of life in a ward, and the cost of hospitalization, is the difference, if he must try to work things out for himself, whether outside or inside the hospital?

The generality of hospitalized patients are, of course, not suited for routine psychoanalysis. Freud, it will be remembered, thought psychotics could not be psychoanalyzed at all until Paul Federn, much to Freud's astonishment, proved the contrary.** But Federn, in method and above all in aim, did not adhere to classical analytic technique with psychotics. His therapy was far more active; and his objective was not the release of repressed material, but the re-repression of material already released by the mental disorder. Similarly, few later serious psychoanalytic workers with psychotics have tried to follow Freud's technique with neurotics. Some of them hold Federn's objectives of re-repression. Others, as in John Rosen's extremely active technique, interpret delusions, hallucinations and other psychotic phenomena "directly"—even more frankly than they might interpret neurotic material brought out in free association. All supervise, direct, restrain and curtail, in ways unthinkable in the treatment of neurotics.

Such modifications of psychoanalytic work with psychotics may obtain in private hospitals, in special research institutions, or in private office practice—with provision for 24-hour-a-day psychiatric nursing service. But there are not enough specialized therapists, and there is not enough money for therapy to provide this

*Schmideberg, Melitta: Values and goals in psychotherapy. PSYCHIAT. QUART., 32:2, 233-265, April 1958.

**Federn, Paul: Psychoanalysis of psychoses. PSYCHIAT. QUART., 17:2 and 3, April and July 1943. Also, Federn, Paul: *Ego Psychology and the Psychoses.* Eduardo Weiss, editor. Basic Books. New York. 1953.

sort of treatment generally for public hospital patients. If there were, one thing is certain: The practitioners would not be "passive."

Commenting on private practice, Schmideberg remarks: "Similar considerations [to those noted in her discussion of self-help and analysis with a silent analyst] apply to 'nondirective' therapy. Unless the therapist does something to modify the material or at least change the emphasis, he is likely to remain not only 'nondirective' but 'nontherapeutic.' ... The mere physical presence of even the most highly qualified practitioner is of little intrinsic value. Psychotherapy is not magic; and even a magician has to exert himself."

The present remarks are suggested, not only by Schmideberg's psychoanalytic discussion, and by observations of current practice, but by the motion picture of psychotherapy, *Out of Darkness,* which has been widely circulated in professional circles and in professional educational circles.* It is a fine piece of mental hygiene and a fine piece of educational material for the informed, attentive and thoughtful practitioner and the attentive and thoughtful student. The operational words here are "attentive" and "thoughtful." For the inattentive and thoughtless will get the impression that here is the way we treat psychotics. And the way that is shown is "nondirective" or "passive" treatment of a catatonic schizophrenic. One can readily acquire the idea that the usual, preferred, or recommended, treatment for a mute catatonic is to sit down opposite the patient for session after session until the patient is moved to reach out a hand or to speak. The picture actually shows weeks of this "passivity," after which rapport is established, the patient speaks her mind, the therapist apparently interprets and encourages—the active therapy is not shown—and there is a rapid recovery. The picture concludes with questions, presumably by Dr. Menninger, as to how many psychiatrists are available for this sort of thing, as to how many of those who are available are capable of it, as to how many patients could benefit by it, and as to how much time and opportunity our hospitals offer for such treatment. The plain inference is that enough psy-

**Out of Darkness.* Orson Welles, narrator; Dr. William C. Menninger, commentator. Distributed by Pennsylvania State University Audiovisual Aids Library. Originally produced by Wyeth Laboratories.

chiatrists who can do this sort of thing, and enough time to do it in, are *not* available—more's the pity.

There are other considerations in this movie case that are not covered adequately in the picture. First, there are frequent "spontaneous" remissions in catatonic schizophrenia. Was this an instance of a delayed one? Second, there is a readily available and effective treatment for catatonic patients that is generally considered to be indicated. Catatonics ordinarily respond readily to shock therapy. Is it wise to let patients like the woman in *Out of Darkness* "hang" for six weeks or so—in the expectation of effective psychotherapy or spontaneous remission—when an effective active therapy is available? These questions should be answered, and other considerations presented, in any educational material designed for general practitioners, residents, medical students and students of the ancillary disciplines.

The question raised here is how many residents, students and laymen will get the plain inference which was conveyed by the picture that the treatment method shown is not practical on a large scale. The Quarterly suggests that the general impression will be more powerful than the inference drawn by the attentive and thoughtful—including the inference that not all mental hospital patients may be suitable for such treatment. When one shows a picture like this, it might be well for the commentator to emphasize that it not only depicts an unusual situation; that there is effective active therapy available for such cases; and that passivity or nondirective therapy is not to be recommended wholeheartedly for the usual mental hospital patient (particularly if "passivity" is misinterpreted to excuse even failure to see a patient regularly).

If the voluntary patient is exempted, the ordinary admission to a public mental hospital is an emergency case. He is either psychotic or the victim of so extreme a psychoneurosis that he is no longer socially acceptable. Help is indicated—and as soon as may be.

Laissez faire is not a practical, humane or effective policy in treating a manic who is prepared to smash the furniture. It is a callous and irresponsible policy with a suicidal depressive. It will not relieve the tension or anxiety of the severe neurotic. If only there were time enough and therapists enough, it might have some rationale or *raison d'être* with such a patient as the catatonic in

Out of Darkness—for there is good reason to allow fear to subside and confidence to return in the withdrawn victim of catatonia. But even here there are modern therapeutic short cuts—such as shock therapy—to hasten this process materially. Except possibly in a research situation, the state hospital therapist in particular is in no position to wait, for the weeks depicted in *Out of Darkness,* or for the months sometimes required in private practice, for a catatonic patient to go through the slow process of "returning to re-birth from uterine withdrawal."

Of course, pure passivity (Why even bother with "tranquilizers"?) is the easiest course. It takes training and a readiness to assume responsibility to embark on any active therapy with a mental patient, either in hospital or private practice. In particular, it requires courage and strength to give shock therapy, even to decide whether shock therapy is needed. To be Dr. Do-Nothing requires only laziness, passivity, and callous disregard for the patient, who may sometimes come to harm that the passive therapist could avert by raising his little finger. When the psychoanalyst accepts a patient for orthodox, nondirective therapy, he tries to make certain, if he is a competent analyst, that the patient is suitable for nondirective therapy and will come to no harm by it. The therapist who uses this one part of the analytic technique for his own unsuitable cases, and risks harm to his patients thereby, is violating the pledge in his oath to "abstain from the deleterious," for refusal of responsibility here is deleterious.

The psychiatrist is unavoidably responsible for the mental patient who comes to him or is assigned to him for help. He cannot shrug off this responsibility without engaging in malpractice. The courageous psychiatrist will not try to shrug it off. And passivity by the psychiatrist—except where clearly indicated in psychoanalytic treatment—is an attempt to shrug it off. The psychiatrist of courage will shun passivity; he will "Do something!" And so will the "good" hospital. It will not hide behind law, regulation or tradition but will promptly and properly care for its patients.

It might be difficult to overvalue the understanding of mental dynamisms and the broad picture of mental disorder that we owe to psychoanalysis. With psychoanalytic insight, we know, or think we know, where and how the emotions have become deranged in the seriously ill mental patient. We even come close, perhaps, in many cases, to knowing why. Here is the application to psychotics

of psychoanalytic research and the demonstration of psychoanalytic theory. In the successful psychotherapist, this amounts to a total of insight it would be difficult to achieve by any other method. But, as applied to psychotic patients in particular, what we have here is a broad understanding, but *only* an understanding, upon which—with sufficient insight and sufficient empathy—the therapist can build a reasonable, and sometimes successful, structure of treatment.

To reach this understanding, is a road of difficult groping, to be traveled slowly and with a painful amount of stumbling, as one acquires enlightened sympathy, overcomes mistakes, and gains experience. The structure then to be built is not necessarily that of conventional analysis; in fact, it is almost necessarily something quite different. Its architecture and its stability will depend largely on the therapist himself.

Freud originally had reasons in addition to the therapeutic for laying down the rule that the analyst must be nondirective. Schmideberg* notes that Freud, particularly when psychoanalysis was new, emphasized its research, as well as its therapeutic, aims. So, she remarks, Freud "attempted to establish a method of scientific observation, trying to eliminate personal bias and disturbing emotional conditions (almost the counterpart of a laboratory) by insisting on a detached, unbiased, and unemotional attitude." This, she points out, is impossible in any event—which may be argued by any so inclined. But assuming it were possible, the preliminary research into psychodynamics has been long since done; the psychotherapist can, when the need of help is urgent, place research in the interest of future patients secondary to therapy for the present one.

As Schmideberg further notes, there are circumstances under which even the neurotic, coming for conventional psychoanalysis, is in desperate need of support. The new hospital patient is almost always in circumstances under which he is in desperate need of support. The hospital is, to him, his last hope and last resort. It is to deprive him of much of this last hope to admit him and then offer him "nothing." And that hospitalization itself is sometimes effective therapy is a poor reason for withholding help from those for whom mere hospitalization is not effective.

The newly-admitted patient is in something like the predicament

*Schmideberg, Melitta: Op. cit., this QUARTERLY.

of Alice—who had to run madly to stay in the same place. He has been running madly, and in spite of all his endeavors, has not managed to stay in the same place. He needs a strong hand and active help—maybe supportive psychotherapy, maybe chlorpromazine, maybe electric shock—not passive permission to go on running. The primary goal of hospital treatment is not restoration of the deranged to theoretical, and probably never-before-experienced normality; it is rather a short stay though not a merry one! It is to restore, if possible, and as soon as possible, the ability of the patient—theoretically well or not—to function in society once more. And "passivity," borrowed from psychoanalysis in an altogether different setting, is not going to help him.

The time is not long past when one visualized the mental hospital as having upon its gates the ancient, time-worn injunction to "abandon hope, all ye who enter here." But that time, if not long past, is well past; the mental institution has become a place of hope, a place the patient can enter with prospect of early return to comparative health and at least adequate social functioning. We no longer maintain custodial infernos; we operate, instead, for the genuine restoration of sick souls. And we cannot offer them nothingness. At the very least, the patient needs the psychiatrist's supporting presence; and the purpose of this discussion is to say that even that sometimes-omitted presence is not enough.

In days gone by, there was a place of resort for country visitors to Paris, working folk and an occasional strayed tourist, operated by a grim humorist—who may or may not have known of Jean-Paul Sartre. It was *Le Café du Néant,* which one may read as "The Tavern of Nothingness." In it, one sat in gloom at coffins for tables, drank revoltingly warm beer and watched the flame on the stub of one's individual candle; as the flame guttered and the candle melted, one's life ebbed. There was short and mildly gruesome entertainment; the picture, high on the wall, of flounced dancers at the *Bal Tabarin,* turning to a transparency of dancing skeletons; a sedate lady visitor from the country being stripped by camera obscura to a *provocatrice* in scanty underwear, then stripped of flesh itself to pose as bare bones in a coffin. The casual visitor, with normal emotions nicely dry-cleaned and pressed, can take such displays of the infantile macabre with a smile.

But the newly-hospitalized mental patient has seen nothing to smile at in his own private *Café du Néant;* he is tortured, torn and shattered by the ghastly sights there. To take him from *Le Café du Néant* to *L'Hôpital du Néant* is no therapy.

It might be well for our therapists to leave to the Existentialists the practice of "Nothing is nothinging."* Maybe, in the hands of an Existentialist analyst, this philosophical concept may lead to benefit for the patient. But the hospital psychiatrist and the therapist in private practice are in no position to indulge in nothinging. The patient is entitled, not to nothing, but to something; and, in the hospital, the psychiatrist must supply the something. "Do something; anything; but something!" is a call from Macedonia that must be heard. *Nil nisi nihil,* nothing except nothing, the emotionally-starving patient will starve altogether on this!

*Kahn, Eugen: Quoting Martin Heidegger, *"Das Nichts nichtet."* Op. cit.

LETTERS TO THE EDITOR

"THE PRESENT WRITER'S CASE"

To the Editor of THE PSYCHIATRIC QUARTERLY:

Sir:

Because THE PSYCHIATRIC QUARTERLY is one of the most interesting and best edited of medical journals, I was a little disheartened to see your footnote to Dr. Federn's article ("Neurotic Style") which appears in the October '57 issue. The footnote explains that Dr. Federn was permitted to use "I" rather than "the writer" because the use of the first person might avoid confusion. Has jargon become so entrenched that standard English usage must be explained?

I think Dr. Nagler (whose article on fetishism appears in the same issue) might have appreciated the same freedom. Then he probably wouldn't have made the eyebrow-raising statement: "Freud is forced to confess that it is not understood why the sight of the penisless female results in homosexuality in some, in fetishism in others (in homosexual fetishism in the present writer's case) . . ."

Dr. Federn pointed out that a "prolix, impersonal manner" may be a "defense against any personal relation with the subject matter" and may shield the author against the danger of writing neurotically. But perhaps this is a danger that psychiatrists, at least, might be willing to face.

I'm sure, though, that all this would have gone unnoticed if your (to me) surprising footnote and Dr. Nagler's clash with the idiom hadn't occurred so close together. So please consider this a minor criticism of a generally excellent journal.

Joseph P. Coogan
Medical Department
Smith, Kline & French Laboratories

* * * *

EDITOR'S NOTE: The editing process was, of course, responsible for Dr. Nagler's unhappy "present writer's case." Dr. Nagler had, very properly, written "my case." Style rules in effect for many years for publications of the New York State Department of Mental Hygiene—rules published in an official manual as long ago as 1937—dictated the change, so, in editing Dr. Nagler's paper, the expression was very properly made to read the "present writer's case." The editors will be first to agree that, in spite of all this propriety, the result was unfortunate—and has been in other instances.

The "third-person rule," that is, the changing of "I" and "we" to "the present writer," "the author," or something equivalent, is observed by many scientific journals other than this one. The purpose is to keep an

irrelevant, or sometimes even unimportant, "I" from getting between a reader and an impersonal scientific discussion. If something like this rule is not in effect, it is possible, as all editors and most writers know, for a personality to burst out all over the place, quite obscuring the data the author wishes to report. The unfortunate alternative is that an editorial artifact sometimes gets between the data and the reader instead. For this reason, THE QUARTERLY, like other journals, has found exceptions necessary or advisable. In Dr. Federn's paper, Dr. Federn was discussing the writer and writing style; it would have been impossible to refer to him also as "the writer" without something like a climax of confusion. In other cases, such as the telling of a personal anecdote or the relating of a personal experience, "I" and "my" are retained—at the editor's discretion—in the interests of clarity and readability.

In all but these very exceptional cases, however, the third-person rule is followed. (The editors apply it to themselves; the time-honored, if not too reputable, editorial "we" is not used in this journal—except on very rare occasions to emphasize that opinion is personal to the editors.) The editors don't like very much to apply the third-person rule to manuscripts; and some authors don't like it at all, though the experienced writers never protest. (Mr. Coogan is an editor, and so has special license to throw spears at his colleagues.) THE QUARTERLY editors will go along with Mr. Coogan, as far as conceding dislike of an artificiality which they would defend only as the least of the evils confronting them. They would welcome letters or other contributions from readers who may see an escape from this dilemma, or who merely have other thoughts on the subject.

—o—

ANOTHER WORD FOR IT

To the Editor of THE PSYCHIATRIC QUARTERLY:

Sir:

Emotional deprivation in early childhood is a well known cause of simulated retardation. At the present time the idea of functional retardation (as shown by psychological testing) with better or normal inherent capacities is expressed by such terms as "pseudo-retardation," "apparent feeblemindedness," or "mental deficiency" or other similar combinations.

I suggest that these cases be called "dysmentia" to indicate disturbance in mental functioning as it applies to the intellectual sphere, and which may be temporary.

This would give a more hopeful attitude toward such patients and *ipso facto* call for further follow-up and/or testing.

Irwin J. Klein, M.D.
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Brooklyn 18, N. Y.

BOOK REVIEWS

Psychotherapy of Chronic Schizophrenic Patients. CARL A. WHITAKER, editor. 219 pages. Cloth. Little, Brown. Boston. 1958. Price $5.00.

Eight heads are better than one. This is especially so when the subject is the treatment of chronic schizophrenia. This book is a verbatim report of the remarks made by eight specialists* in a discussion about the psychotherapy of schizophrenics. Diagnosis, orality, anality, the family situation, communication and counter-transference are discussed in relation to therapy. The discussants are frank about their own feelings and often disagree with one another.

The participants leave no doubt of their feeling that schizophrenia results from abnormal relationships within the family group. Most of them feel emphatically that the whole family is mentally ill and that all its members must participate in therapy.

Much of the resentment and hostility—both in and out of the psychiatric literature—that has been directed at some of the participants in this discussion stems from their extremely critical attitudes toward management of the patient in the hospital. Granting that all the hospitalized patients with schizophrenia who are able to make social recoveries do not do so, and that many who show further regression in the hospital do so because of mismanagement by the personnel, it should be mentioned that many of the discussants here frankly admit that the patient can also be mismanaged by the therapist outside the hospital setting.

This reviewer thinks that curbing of destructive criticism of both therapist and administrator is needed, and that the handful of therapists doing intensive psychotherapy with schizophrenics should be encouraged—recognizing that these workers are only on the threshold of understanding schizophrenia and developing techniques to help schizophrenic patients. These therapists in turn must consider the administrator and the overwhelming problems he faces, realizing that many administrators are not the therapeutic nihilists they are often made out to be, and that they must deal, not only with the patient, but with the therapist, and the family, all of whom may not be facing reality.

Experimental Psychology—Revised. By ROBERT S. WOODWORTH and HAROLD SCHLOSBERG. 948 pages. Cloth. Holt. New York. 1954. Price $8.95.

Woodworth's first edition of *Experimental Psychology* in 1938 became the standard text for most experimental psychological classes. In the last

*Gregory Bateson, M.A.; Malcolm L. Hayward, M.D.; Donald D. Jackson, M.D.; Thomas P. Malone, Ph.D., M.D.; John N. Rosen, M.D.; J. Edward Taylor, M.D.; John Warkentin, Ph.D., M.D.; and Carl A. Whitaker, M.D.

quarter century, however, there have been a considerable number of experimental studies which attempt to meet newer and more rigorous criteria set by the scientifically-oriented psychologist. And it is in part to meet the need for a text which draws together an adequate and representative sampling of this more recent work, that Woodworth and Schlosberg revised *Experimental Psychology*. The new bibliography contains 40 per cent more titles than the old one—2,480 as compared with 1,770. More than half of the books and articles cited in the revised edition did not appear in the old. Other important changes in content appear; much of the material on "feeling," and on "experimental esthetics" has been omitted; "emotion" has been more extensively treated. Important new chapters have been added. The revised edition should be a necessity for the academic psychologist, as well as a valuable aid for the clinician.

The Case History of Sigmund Freud. By MAURICE NATENBERG. 245 pages including index. Cloth. Regent House. Chicago. 1955. Price $3.95.

Natenberg, who is described on this book's dust jacket as a medical writer and editor, calls Freud "the cleverest charlatan the world has ever known," but he does not make a very convincing argument. Freud's concepts of the unconscious, of dreams, of personality development and so forth were not entirely unknown before his time.

Like many other geniuses, Freud integrated facts into a practical theoretical concept; and what Natenberg calls his "delusions" would have been discovered and formulated by others if Freud had not lived. The author holds "... his [Freud's] greatness was achieved through the driving force of the demons within him; the bedevelling obsessions; compulsions and inordinate vanity which gave him no peace and demanded unqualified belief in his genius." So what! The driving forces of Van Gogh, of Lincoln, of Keats, to name a few, were probably results of their conflicts but this does not detract from their accomplishments. Freud was human, and, like all humans, had many undesirable traits. But no one except the most prejudiced and unreasonable and misinformed person would say as this author does that, "the harm he [Freud] has done to the course of valid science and authentic psychotherapy is incalculable."

Freud's followers, as well as Freud, come in for a share of the venom. There is, for instance, an unjustifiable, inexcusable, unforgivable—and airily off-hand—slur on the late Paul Federn.

A House on the Rhine. By FRANCES FAVIELL. 256 pages. Cloth. Farrar, Straus and Cudahy. New York. 1956. Price $3.50.

The moral decay of a German family in postwar Europe is dramatically portrayed in this well-written story. It deals with such postwar realities in Germany as the black market, violence, theft, and prematurely corrupt youth.

Psychosomatic Medicine. A Clinical Study of Psychophysiologic Reactions. By EDWARD WEISS, M.D., and O. SPURGEON ENGLISH, M.D. Third Edition. XIX and 557 pages including eight illustrations, references and index. Cloth. Saunders. Philadelphia and London. 1957. Price $10.50.

The third edition of this famous textbook on psychosomatic medicine has changed considerably in volume, content and range, since the second edition was reviewed here. Two hundred fifty fewer pages make the book more compact, and the authors have rewritten large parts of the unique text which serves not only one specialty, but is already indispensable to the physician from general practitioner to specialist. Its range reaches from personality development to highly specific problems in virtually every field of medicine; from fundamentals of psychopathology to the psychological problems facing the surgeon; from a physician's everyday difficulties to marital and, eventually, geriatric problems. *Psychosomatic Medicine* may be a design for a future super-handbook of medicine which will guide the medical student from entering medical school to the final achievement of his individual goal as a physician. The book already belongs in the hands of the student, as well as those of the seasoned physician.

Fantasia Mathematica. CLIFTON FADIMAN, editor. 298 pages. Cloth. Simon and Schuster. New York. 1958. Price $4.95.

Clifton Fadiman was only, only fooling when he put together this collection of mathematical and science-fictional anecdotes and mathematical curiosities. A number of the stories are based on topological theory, including several on the Möbius strip. The collection is for people who enjoy reading about mathematics rather than doing sums, and it will place no strain on the ordinary scientific reader. As might be supposed, a number of the selections are quite as psychological as mathematical, and semantics is frequently as important as arithmetic. Jurgen's mathematical proof that he was a man of flesh and blood will never be taught in high school; and Schnitzler's conclusion that "dying is itself Eternity and hence, in accordance with the theory of limits, one may approach death but can never reach it," is something for the attention of any psychologist. It is, of course, the fallacy of Achilles and the tortoise.

The Psychoanalytic Study of the Child. Volume XII. RUTH S. EISSLER, et al. editors. 417 pages. Cloth. International Universities Press. New York. 1957. Price $8.50.

This worthwhile yearly publication sometimes produces a good compilation of studies, only to bring out at other times repetitions of the already known and repeatedly described. The present volume belongs

in the second category. This is regrettable. It is also regrettable that the editors do not use more influence in editing. E.g., when one author states: "Neither am I reviewing the work of others who have contributed to this subject. There has been a great deal written that I have not yet had a chance even to read..." he could be asked editorially to read first, and publish later. Or, when another admits, "In the present instance, the unfortunate fact of her mother's death caused this patient to experience an adolescence that is *not* typical," only to draw far-reaching conclusions from an atypical example, some editorial interference is advisable. And so on.

The Mental Hospital. By Alfred H. Stanton, M.D. and Morris S. Schwartz, Ph.D. XX and 492 pages. Cloth. Basic Books. New York. 1954. Price $7.50.

This book attempts to portray the mental hospital patient in his sociological setting—the ward. It is often forgotten that the ward is the patient's home, and that disrupting factors in the home influence the personality and adjustment—whatever this home may be. It is not surprising that the investigators found much correlation between the smooth functioning of the ward and the improvement in the patients.

The authors investigated the conflicts and tensions between persons working with the patients—both from the standpoint of individual differences and the differences that exist between the different levels of work —doctors, nurses, and aides. The reviewer believes this to be an important book. It has become increasingly apparent that the welfare and recovery of the mentally ill depend to a large measure on people.

Intensive studies on patients must include the study of the patient's environment. Chestnut Lodge, where this study took place, is perhaps not typical of mental hospitals. The approach of the authors, which appears to be strongly influenced by the teachings of Harry Stack Sullivan, might also be questioned by some readers. Nevertheless, the problems the authors bring out are very real and very pertinent in all state hospitals.

Aids To Psychiatric Nursing. By A. Altschul, B.A., S.R.N., R.M.N. XII and 281 pages. Cloth. Williams & Wilkins. Baltimore. 1957. Price $2.50.

This book, published in England, is designed as a complete text in psychiatric nursing for students. In comparison with American texts, the appearance of the book is not impressive. It is pocket size, without illustrations, with an indifferent grade of paper, and has small print. Luckily, the contents are much more impressive than the appearance. The approach to psychiatric nursing is both sound and sensible, with the

emphasis on nursing care rather than clinical psychiatry. The language used is very simple, without "talking down" to the students.

Undoubtedly, many nursing educators in this country would not consider this book adequate in covering the field—either in clinical psychiatry or in the concepts of interpersonal relations—but particularly during the beginning of a psychiatric nursing course, this book has many advantages of simplicity and clarity often lacking in other texts. This reviewer strongly advises school of nursing educators and those concerned with training programs for attendants to look over this work to see if it has applications in their curricula.

How Communists Negotiate. By Admiral C. TURNER JOY. 178 pages. Cloth. Macmillan. New York. 1954. Price $3.50.

As senior United Nations delegate during the Korean armistice conference, Admiral Joy had the opportunity of observing Communist tactics; and he reports skillfully the numerous tricks, prevarications, lies, underhanded tactics of the Red delegates. This is a valuable and highly informative book.

Art By Subtraction. By B. L. REID. 207 pages. Cloth. University of Oklahoma Press. Norman, Oklahoma. 1958. Price $4.00.

Professor Reid writes a criticism of Gertrude Stein which he says was "born of a gradual disenchantment." Reid, who teaches English at Mount Holyoke, has been interested in Gertrude Stein since his own college days. He approached her early work with admiration but believes that her mind "became progressively more complex and idiosyncratic until at last there was no single mind, let along group of minds, to which it could communicate effectively." He believes she wrote with great labor and great pains but that she had created a private language, perhaps analogous to the schizophrenic (though certainly not schizophrenic in origin) which finally became incomprehensible to anybody else. Reid merely thinks that she had a "pathological ability to compartmentalize her mind that I have called near schizophrenic." He thinks much of her work "unfortunately" too dull to have sprung from the unconscious. He believes she had a very real intelligence in spite of the "stupid quality" of much of her writing. He thinks her Lesbian novel, *Things As They Are*, portrayed herself doing "virginal and intellectualized [homosexual] flirting." He suspects overt sex was distasteful to her in both life and literature.

Reid thinks that Gertrude Stein is already dead as a writer, that nobody reads her although everybody talks about her. He thinks her literary importance is a myth although he finds her "enormously interesting as a phenomenon of the power of personality and as a symptom of a frantic, bumbling nightmare age."

September Moon. By JOHN MOORE. 317 pages. Cloth. Lippincott. Philadelphia. 1958. Price $3.95.

This is a story of the Herefordshire countryside during the hop-picking season. Through the month of September the quiet farm country is invaded by the fighting gypsies, the rough workers from the Midlands, and a group of uninhibited Welsh factory girls. To all this variety of characters, the author brings an amazingly keen insight, and his descriptions of the charming English countryside are unforgettable. Not the least part of the book is its sincerely moving love story.

A sensitively written and delightful piece of writing, this makes a happy addition to any book shelf.

The Personality of the Cat. BRANDT AYMAR, editor. 341 pages. Cloth. Crown. New York. 1958. Price $4.95.

Charles Darwin wrote provocatively of emotions in the animal; but comparative psychology since has concentrated most of its attention on the "intellectual" faculties. The conditioned reflex, learning ability and reasoning ability have been matters of major interest. In most such studies, how an animal feels rather than how it "thinks" has appeared to be something of a minor matter.

The Personality of the Cat is a compilation collected in the first place for people who are fond of cats. Unfortunately it could not be written by cats, but merely by human interpreters of what and why cats do and feel. It is naturally not a scientific book although there is some rather careful observation, notably in the essay by Frances and Richard Lockridge. It is difficult to see how the elements of human interpretation could be lessened much further than in this Lockridge contribution, although this reviewer would like to see more serious scientific study of animal emotion.

Too many animal tales, including some in this book, are what Teddy Roosevelt, presumably referring to Kipling, called "nature-faking." Cathy Hayes' study, *The Ape in Our House*, is a notable recent exception, and some of the cat stories in the present collection could take their place with it. The dynamic psychologist is convinced that 99 per cent or more of human mental activities are emotional, not intellectual. It is reasonable to presume that an even greater proportion of animal "mentation" is emotional. In the absence of sound scientific studies, a work like Aymar's is commended to the attention of anybody who has an interest in comparative psychology.

Pavlov and Freud. Volume I. By HARRY K. WELLS, Ph.D. 244 pages including index. Cloth. International Publishers. New York. 1956. Price $3.50.

This is an excellent introduction to the work of the great Russian scien-

tist, Pavlov, with reference to its implications for psychology and psychiatry. The book is fairly lucid but biased. There is little doubt in the reviewer's mind that Freud is going to come out second best in Volume II when his theories are presented: At least, certain statements in this volume would make one think so.

The author also throws in a good deal of propaganda favorable to Russia. For instance, he writes that psychology in Russia is free of its shackles because capitalism has been eliminated. In the United States, because "imperialism puts even more reactionary demands on psychology and for lack of familiarity with the science of higher nervous activity, the physiological basis of man's mental activity remains largely unknown."

No doubt Pavlov made many contributions to physiology, and especially neurophysiology. These in turn have implications for a concept of man and his behavior. However, when it comes to the therapy of the neuroses and psychoses, his contribution has not been great in spite of the extensive claims made for it in this book. His claims, like the claims of many others with different theoretical backgrounds, are almost impossible to verify or validate because of the lack of controls and because of the great number of variables in the treatment of the mentally ill. Until therapeutic claims are verified, one has the right, or the duty, to be skeptical.

Sociological Theory. Its Nature and Growth. By NICHOLAS S. TIMASHEFF. xv and 328 pages. Cloth. Doubleday. New York. 1955. Price $4.50.

Professor Nicholas S. Timasheff of Fordham attempts, in *Sociological Theory*, to gather facts, and treat them statistically and with philosophic insight, over the entire area of sociological theory. Actually, his book is a study in the history of sociological ideas. It is, however, unfortunately too "textbookish," and in places is rather dated in its argument. As a source book, it is sound and may be referred to for a brief study of sociological thinking, not alone of American origin but of European as well.

The Psychiatric Study of Jesus: Exposition and criticism. By ALBERT SCHWEITZER, M.D. Translation and introduction by CHARLES R. JOY. Foreward by WINFRED OVERHOLSER, M.D. 79 pages including index. Paper. Beacon Press. Boston. 1958. Price 95 cents.

This is a critical look at the idea of some writers that Jesus was psychopathic, and/or paranoid. The evidence appears to be very tenuous as Schweitzer so ably points out. Schweitzer makes the point that the sayings of Jesus have to be considered in the social and religious ideation of the time in which he lived. Removed from this background, many of his ideas would be considered delusional and bizarre. Overholser further points out in the introduction that diagnosis without a good case history, and diagnosis from a distance are perilous.

Sexual Symbolism. (A Discourse on the Worship of Priapus. By Richard Payne Knight. 217 pages. The Worship of the Generative Powers During the Middle Ages of Western Europe) By Thomas Wright. 196 pages. Cloth. Julian Press. New York. 1957. Price $7.50.

Sexual Symbolism is a re-issue in one volume of two out-of-print and valuable books. (It is published by the Julian Press, which is also re-issuing Frederick Thomas Elworthy's *The Evil Eye.*) These are pioneer books in the field of phallic worship and of general sex worship. The psychiatrist, in particular the psychoanalyst, should find both of them interesting and fascinating.

Knight's book, *A Discourse on the Worship of Priapus,* was published in 1786; and Wright's *The Worship of the Generative Powers During the Middle Ages of Western Europe* appeared in 1866. Thus neither includes modern psychosexual speculation, but they both contain valuable source material.

The Evil Eye. By Edward S. Gifford, Jr., M.D. 216 pages including index. Cloth. Macmillan. New York. 1958. Price $4.95.

The Evil Eye. By Frederick Thomas Elworthy. 471 pages including index. Cloth. Julian Press. New York. 1958. Price $7.50.

Dr. Gifford's book on the evil eye appears simultaneously with a reprint of Frederick Thomas Elworthy's 1895 book of the same title on the same subject. The two volumes trace the history of one of the most prevalent and fascinating of superstitions. Gifford's shorter treatise is, of course, up-to-date and takes account of the contributions of psychiatry and psychoanalysis to the subject of folklore. It is a readable and apparently reliable volume.

Elworthy's book was a fine piece of scholarship in his day. It is profusely illustrated, which the Gifford book is not, and it covers the subject very thoroughly. There are a few remarks which the modern psychiatrist would find quaint, to the effect that this or that cannot be printed or is not fit to print. Elworthy seems to have had an inkling of the psychodynamics but by no means an understanding of them. Gifford does understand and explain adequately.

Both books give excellent discussion of the common amulets and gestures used to avert the evil eye. The fact that a person may be reputed to have an evil eye without his own will and still be a notably good man is illustrated by two popes, Pius IX and Leo XIII, both of whom were supposed to have had this affliction. Strangely, to this reviewer at least, Dr. Gifford does not mention one explanation which the reviewer has supposed to be basic for the superstition—that the evil eye is the vagina dentata. Either of these books would be an addition to any scientific library. Elworthy's is published with a masterly piece of bookbinding that one would not recommend to a severe neurotic or a person with paranoid trends.

Six Days or Forever? By RAY GINGER. 258 pages including index. Cloth. Beacon Press. Boston. 1958. Price $3.95.

The reviewer of *Six Days or Forever?* has a very vivid recollection of the case of Tennessee vs. John Thomas Scopes—the famous monkey trial. By the standard of that personal recollection, Ginger's book is a very fine presentation of what went on from the time a Tennessee legislator introduced a bill to protect the state's children from the teaching of evolution to the death of William Jennings Bryan who became one of two great principals in the case as an attorney for the prosecution and witness, despite himself, for the defense.

This is a very sobering record for any scientist or student of science. From it, emerges the disturbing fact that neither the trial court nor any appeals court passed on the major issue—that of academic freedom. The offending anti-evolution law is still law in Tennessee, with the most recent effort to repeal it defeated in 1951.

The author reviews the whole affair very capably and very readably. The account of Clarence Darrow's examination of Bryan, whom he called as a witness, is extraordinarily good. As a very minor matter, it is to be regretted that the author did not make note that Darrow said privately —and probably publicly—after the trial that if he had realized the extent of Bryan's senile mental deterioration he would not have called him to the stand and humiliated him. The reviewer thinks this book is important to every American educator and every American scientist.

The Psychology of Early Childhood. By CATHERINE LANDRETH, Ph.D. 425 pages including index. Cloth. Knopf. New York. 1958. Price $8.75, Trade; $6.50 Text.

This is a refreshing study of the psychology of the infant and child up to the age of six. Included in the book is a chapter on the pre-natal origins of behavior and one on the problems inherent in the study of human behavior. Each chapter begins with a number of questions, and an attempt to answer them is then made. At each chapter's end, there is a recommended reading list, and sometimes a number of films are also recommended.

The Neuroses and Their Treatment. EDWARD PODOLSKY, M.D., editor. 555 pages. Cloth. Philosophical Library. New York. 1957. Price $10.00.

This book is a collection of 37 articles by different authors, who describe the neuroses and neurotic symptoms in children and adults and some of the major therapeutic measures used in their treatment. Although various psychotherapeutic measures are emphasized, somatic and pharmacological therapy are not entirely neglected. This is an interesting book but, of course, lacks any continuity of ideas because of the diverse backgrounds of the authors and the vastness of the subject.

Have Psychoanalysts a Place in Medicine? By HENRY A. TURKEL, M.D. 16 pages. Paper. Published by the author, 8000 W. Seven Mile Road, Detroit, Mich. No price stated.

This pamphlet is reviewed at the request of the author, who submitted it to accompany a criticism of THE QUARTERLY'S review of *Induced Delusions,* an attack on psychoanalysis by Coyne H. Campbell, M.D. (Vol. 31:4, 786, October 1957). The reviewer had based his review partly on Campbell's all-inclusive denunciation of Freud and partly on Campbell's use of a Freudian interpretation to attack Freudian doctrine; and Dr. Turkel took exceptions. In his own pamphlet, Dr. Turkel who says his "primary interests are in internal medicine and allergies" but that his efforts have "extended to the study of psychological influences"—makes his opinion emphatically plain that psychoanalysts do not have a place in medicine. "Since it appears that the American Psychiatric Association is unable to rid itself of its psychoanalytic members," he thinks it is now imperative for the American Medical Association to take over control of the psychiatric association and order the analysts' expulsion, withdrawing the psychiatric association charter if the order is not carried out. Dr. Turkel sets down his reasons in his pamphlet, which presumably can be obtained on application to the author. The reviewer thinks that many psychiatrists, including many psychoanalysts, will find it interesting and possibly profitable reading.

Chronic Schizophrenia. By THOMAS FREEMAN, M.D., JOHN L. CAMERON, M. B., and ANDREW MCGHIE, M.A. 158 pages including index. Cloth. International Universities Press. New York. 1958. Price $4.00.

This book presents a very good study of the patient with chronic schizophrenia. It is analytically oriented—with emphasis on disturbance of ego function, or inability to function, as the basic disturbance—without etiological assumptions as to why this happens. There are chapters on disturbances of perception, thinking and memory; and one chapter describes the research treatment program for chronic schizophrenics set up by the authors at the Glasgow Royal Mental Hospital in Scotland.

On the basis of their study, the authors make two following recommendations: 1. It is essential that the nurse not be shifted from ward to ward —as, with such shifting, the patient is unable to form a durable relationship with her, or vice versa. 2. The nurse's function must be broadened, to enhance the therapeutic potential in the nurse-patient relationship.

Christian Essays in Psychiatry. PHILIP MAIRET, editor. 187 pages. Cloth. Philosophical Library. New York. 1956. Price $4.50.

This book is composed of 10 essays by psychiatrists, psychologists and theologians. The essays are basically concerned with the conflicts between the ideas of the religionist and those of the psychiatrist; and, as so often

happens, much conflict is resolved when terms are defined. Often, one word is used with different meanings by the different groups. Naturally, all the conflicts noted are not resolved this way here; but the elucidation of points of conflict by psychiatrist and religionist cannot but help toward better understanding on both sides. After all, the quest of both is, or should be, the truth. And there should be no objection to a critical look at what one feels is the truth.

The Passionate Exiles. By MAURICE LEVAILLANT. 350 pages. Cloth. Farrar, Straus & Cudahy. New York. 1958. Price $4.75.

This book is a dual biography of Mme. Recamier and Mme. de Stael, but it is also the re-creation of a historical period, the turbulent years following the French Revolution, and is a fascinating picture of the social and intellectual life of Europe. The story of the friendship between these two extraordinary and vastly dissimilar women involves, directly or indirectly, every major figure of this period. To anyone interested in this era, the book should, from a sociological standpoint, be of great value.

The Dynamics of Interviewing. By ROBERT L. KAHN, Ph.D. and CHARLES F. CANNELL, Ph.D. 368 pages including index. Cloth. Wiley. New York. 1957. Price $7.75.

The authors state in the preface that "the thesis of this book is that in order to be a successful interviewer, a person must know and understand these dynamics—the psychological forces at work in the interview." As a result of this belief, this book is oriented toward explaining by theory—and with copies of verbatim interviews—the dynamics between the interviewer and the respondent. The authors believe that technique without understanding is sterile, superficial and of limited worth. This book should be of value to professional people in many fields.

Letters of the Brownings to George Barrett. PAUL LANDIS, editor, with the assistance of RONALD E. FREEMAN. 333 pages. Cloth. With five appendices, family group list, eight illustrations and index. University of Illinois Press. 1958. Price $6.50.

This carefully documented work contains 88 letters written by the Brownings to Elizabeth's brother, George. Fifty-eight were written by Elizabeth, the other 30 by Robert, after Mrs. Browning's death. Elizabeth's letters serve to point up the psychopathology of the Barrett family, and Robert's give a clear picture of his own seclusive attitude. This correspondence is—up to the present time—the most complete and continuous record available of Browning-Barrett relations. Appendices, the family group list, the index, and plates add much to this volume.

When Men Are Free. Premises of American Liberty. By The Citizenship Education Project. 167 pages. Cloth. Houghton Mifflin (for Teachers College, Columbia University). Boston. 1955. Price $3.75.

In an extremely interesting and attractive format, the Citizenship Education Project has issued *When Men Are Free: Premises of American Liberty,* a volume dealing with the basic principles of democracy. As indicated in the preface, the "premises" of liberty are deemed to be the assumptions or are based on the assumptions, which the founding fathers made when they wrote the constitution.

In sufficiently scientific yet readable fashion, *When Men Are Free* deals with basic social beliefs, basic social guarantees, human rights to life and liberty, rights of fair trial, freedom from unjust laws, and social responsibilities of the individual. Other headings and tenets dealt with relate to constitutional checks on governmental power, political responsibilities of a citizen in America, basic economic goals, the rights of property, the privileges of individual enterprise, and the privileges of individual labor. The volume concludes with a strong statement on "The Free World," which deals pointedly with the premises guiding foreign relations. Psychiatrists, psychologists, social workers, teachers, and parents, may well refer to this volume for unequivocal and direct statements of viewpoint to bolster democratic action.

An Introduction to Clinical Psychology. 2d Edition. L. A. Pennington and I. A. Berg, editors. vii and 709 pages. Cloth. Ronald Press. New York. 1954. Price $6.50.

An Introduction to Clinical Psychology, edited by L. A. Pennington and I. A. Berg, provides a sound survey of the field of clinical psychology, its opportunities, responsibilities, and approaches. This book is a new edition, with added chapters and differing nuances of interpretations. The text reflects the diverse views and methods of practising clinicians. The authors feel that clinical psychology has matured in self-awareness and in asserting its right to a comparable status with psychiatry and other disciplines. Its maturity is also reflected in its concern with matters of ethical behavior.

Among the fine array of contributors, are Cattell, "The Meaning of Clinical Psychology"; Shoben, "Theoretical Frames of Reference in Clinical Psychology"; Mowrer, "What is Normal Behavior?"; Sargent, "Projective Methods"; and Saslow, "Psychosomatic Medicine and the Psychologist."

Explorations in Awareness. By J. Samuel Bois. 203 pages. Cloth. Harper. New York. 1957. Price $3.50.

A Canadian management consultant attempts to explain Alfred Korzybski's "general semantics," life and human actions in general. By attempting too much (especially while paying little attention to unconscious mechanisms), he achieves more confusion than clarification.

Conjugal Life. By HONORÉ DE BALZAC.. 230 pages. Cloth. Associated Booksellers. Westport, Conn. 1957. Price $3.75.

This book has long been famous in Europe for its combination of disillusionment and practicality about marriage. It is superficial, is largely a discourse on the manners and morals of the upper class French under the Second Empire, is snobbish, is out of date—and is extremely clever. Because of, as well as in spite of, all this, the present translation should be of considerable interest and some value to any student of psychology or sociology.

Judas The Betrayer. By ALBERT NICOLE. 81 pages. Cloth. Baker. Grand Rapids. 1957. Price $1.50.

Judas The Betrayer is subtitled "A psychological study of Judas Iscariot." Its author is a minister of the Swiss Free Church. The book is not psychological in the scientific sense. It is religion, not psychology; and it treats of Judas as a man tempted by the devil to sin, overcome by the temptation and by jealousy of Jesus, and at the end, remorseful.

The Wise Children. By CHRISTINE WESTON. 375 pages. Cloth. Scribner. New York. 1957. Price $4.50.

The author of *Indigo* and *The World Is A Bridge* departs from her Indian background, and writes a story about two New York sisters and their children. Regretfully, one has to state that the story-line is far-fetched and that neither alcoholism, nor infidelity, nor misjudgments of children concerning their parents are so daring in literature as Miss Weston seems to assume. The characterizations, especially the propelling inner motives, are not worked out.

From Ape to Angel. By H. R. HAYS. 440 pages and index. Cloth. Knopf. New York. 1958. Price $7.50.

From Ape to Angel is an account of the principal figures who created the science of social anthropology—a stepsister science to psychiatry if not one of closer relationship. Hays starts with the life and work of Henry Schoolcraft who was the world's first great ethnologist, and brings the account to the present-day studies which have been so greatly influenced by psychoanalysis and other psychiatric contributions. Of contemporaries, there are sketches of John Dollard, Gregory Bateson, Ashley Montagu, Margaret Mead and others who have had almost as much influence in psychiatry and mental hygiene as in their own discipline. This is a readable and informative book for any student, for the armchair anthropologist and for the social scientist in general. It should be of considerable reference use, as well, in any library of social science.

Parent-Child Tensions. By BERTHOLD ERIC SCHWARTZ, M.D., and BARTOLOMEW A. RUGGIERI, M.D. 238 pages including index. Cloth. Lippincott. Philadelphia. 1958. Price $4.95.

This is a fairly good book for parents on parent-child relations and interactions.

However, it is analytically oriented; and, for this reason, many of its explanations may not be accepted by the very parents who need help the most, because the parents' own problems and resistances will interfere. For the fairly well-adjusted parent, however, the book should help in understanding the child.

A Parents' Guide To Children's Illnesses. By JOHN HENDERSON, M.D. 398 pages with index. Cloth. Duell, Sloan and Pearce. New York. 1957. Price $4.75.

This is a book that should appeal to parents. It is simple, yet thorough and explicit. For most illnesses, the treatment recommended is a visit to the doctor. However, emergency measures for acute maladies, poisons and accidents are given. A very complete glossary of medical terms is also included.

The Man in the Net. By PATRICK QUENTIN. 251 pages. Cloth. Simon and Schuster. New York. 1956. Price $2.75.

This is a mystery story of no great depth which is concerned, among other things, with a group of entirely believable children and a psychopathic alcoholic woman. It is no exposition of psychology but it is entertaining and it is believable.

Culture and the Structural Evolution of the Neural System. By F. A. METTLER. 54 pages. The American Museum of Natural History. New York. 1956. No price given.

This book represents the contents of the author's James Arthur Lecture on the "Evolution of the Human Brain," delivered in 1955. The author is professor of anatomy, College of Physicians and Surgeons, Columbia University. His conclusions read:

"Attention has been drawn to the fact that there is no good evidence to support the assumption that man's neural system has undergone any progressive alteration in the direction of greater size or complexity since the middle of the Pleistocene. It was at this period that cultural development became manifest, and the hypothesis is advanced that, with the advent of culture, man achieved a degree of independence from his environment and was therefore no longer under the necessity of developing structural modifications to survive. Consideration is drawn to the fact that the culture has itself become a selective factor in his development and has resulted in great variation in the species."

Sometime, Never. By WILLIAM GOLDING, JOHN WYNDHAM and MERVYN PEAKE. 185 pages. Paper. Ballantine. New York. 1956. Price 35 cents.

Sometime, Never is a collection of three short science fiction novels, or perhaps long short stories, which convey more to think about than most of their ilk. Golding's "Envoy Extraordinary" is a tale of what happened to an inventor of certain scientific devices which threatened to upset the society of the Roman Empire. The psychology of the emperor, who wanted no part of this, is a commentary on those among us who would turn the clock back to the pre-atomic age.

The other two stories involve a manless world with artificial parthenogenesis and the dream—if it was one—of a medieval small boy lost in a schizophrenic world.

No and Yes: On the Genesis of Human Communication. RENÉ A. SPITZ, M.D. 170 pages including index. Cloth. International Universities Press. 1957. Price $4.00.

This is a study of the pre-verbal beginnings of communication as seen in the infant. It is interesting, although very complex; and the reader must have a good background of psychoanalytic knowledge to understand the author. The approach is strictly Freudian. This and other studies of pre-verbal communication are very important when one considers that, during this very early period of life, the infant is very susceptible to psychic trauma. Certainly, to some extent, an understanding of schizophrenia awaits further knowledge about communication.

Community Programs For Mental Health. Theory, Practice and Evaluation. RUTH KOTINSKY and HELEN L. WITMER, editors. 357 pages. Cloth. Commonwealth Fund. Cambridge, Mass. 1955. Price $5.00.

In this compilation of discussions of community mental health programs, Dr. Sol Ginsburg makes an important point when he states "one of the great theoretical lacks in mental hygiene activity seems to me to be that we do not have an adequate definition of mental hygiene. . . . The borderline between mental health and illness . . . fluctuates from one cultural, socio-economic setting to the next. . . "

It is because of this confusion of definition, Dr. Edith Tufts believes, that there is general lack of a specific community organization which can feel entirely responsible for promoting a program. In one community it may be the task of a "Junior League" and in another it may be the Health and Welfare Department.

Other contributors to this useful volume are: Dr. H. E. Chamberlain and Elizabeth deSchweintz; Dr. Barbara Biber; Dr. Louisa P. Howe; Dr. Marie Jahoda; and Dr. Robert R. Holt.

The Allergic Child. By HARRY SWARTZ, M.D. 285 pages. Cloth. Coward-McCann. New York. 1954. Price $3.95.

Since, according to the author, there are about five million children under 14 who suffer from some form of allergy, this book should be of considerable value to parents. Dr. Swartz defines allergy; tells how and when it begins in the child; what superstitions there are relative to it; what environmental elements may cause it; and what precautions may be taken. He describes the common allergic manifestations; calls attention to emotional factors, and, finally, describes methods of treatment.

Psychotherapy of the Adolescent. BENJAMIN HARRIS BALSER, M.D., editor. 270 pages including index. Cloth. International Universities Press. New York. 1957. Price $5.00.

This book is composed of a number of articles by experts in the field of psychotherapy of the adolescent. It deals with psychotherapy at different levels, in private practice, school, clinic, and with the in-patient. Many problems that arise in psychotherapy are discussed; and the normal, or usual, adolescent pattern is described and differentiated from the abnormal. This book should be of value to educators and psychiatrists.

Analyzing Psychotherapy. By SOLOMON KATZENELBOGEN. 120 pages. Cloth. Philosophical Library. New York. 1958. Price $3.00.

The "purpose of this monograph," says the author, "is mainly to describe my own concept of psychotherapy. It derives essentially from my understanding of the psycho-biological school of psychiatry as taught by Adolf Meyer." The book is an exposition of the "rational psychotherapy."

Psychobiology: A Science of Man. By ADOLF MEYER. 257 pages including index. Cloth. Thomas. Springfield. 1957. Price $6.50.

This book is composed of the three Salmon lectures that were delivered by Meyer in 1931. The lectures deal with psychobiology, psychopathology and therapy, and give the reader an excellent concept of Meyer's formulations which had, and still have, much influence on American psychiatric thought.

The Young Life. By LEE TOWNSEND. 228 pages. Cloth. John Day. New York. 1958. Price $3.95.

A good topic is butchered by the author's psychological ignorance in this British novel. An adolescent girl is raped by a gang of nine juvenile delinquents. What follows is naïve, the reviewer thinks, despite entrance of a psychiatrist on the scene. The author seems determined to prove that the incident is ineradicable, and injustice is predominant.

The Mackerel Plaza. By PETER DEVRIES. 260 pages. Cloth. Little, Brown. Boston. 1958. Price $3.75.

Peter DeVries writes light-hearted and superficial stories of matters moral—and of psychological dilemma. *The Mackerel Plaza* concerns the young widowed minister of a liberal church, whose hopes to remarry are being thwarted by attempts to make his dead wife a sort of patron saint of his fashionable Connecticut town. The book is entertaining and its situations amusing. Furthermore, in the gradual untangling of the various emotional relationships to the minister's dead wife, there is a surprising amount of sound psychology.

They Came To Cordura. By GLENDON SWARTHOUT. 213 pages. Cloth. Random House. New York. 1958. Price $3.50.

Here is the second book by a young writer whose work—at least judging by this story—is far above average.

This novel concerns itself with an awards officer in the campaign of 1916 against Pancho Villa, and the five men and one woman in his charge. How the major deals with these people, his obsession, compulsions and the expiation of his own guilt, make for a psychologically accurate tale, and one of hair-raising suspense. An excellently done piece of writing that should be of interest to one and all.

Of Love and Lust. By THEODOR REIK. 623 pages. Cloth. Farrar, Straus & Cudahy. New York. 1957. Price $7.50.

Of Love and Lust is a compilation from three previously published works and a new and previously unpublished discussion on the emotional differences of the sexes. In Part One the editors have selected material from *A Psychologist Looks at Love*, which has been out of print for some years. It develops Reik's thesis that love, contrary to Freud's assumption, does not arise from the sex instinct, but is a construction of the ego and ego ideal. Reik considers love "the most successful attempt to escape our loneliness and isolation. . . . It is an illusion like every search for human perfection, but it is a necessary illusion." Part Two is similarly made up of material from Reik's well-known work, *Masochism in Modern Man*. Part Three, "The Unmarried," is made up of two essays for a symposium edited by Hilda Holland. Reik discusses the fears and resistances of both men and women to accepting marital obligations.

"The Emotional Differences of Sex" which makes up Part Four of this book is material never published previously. Reik reviews literature, and cites numerous clinical examples to show differences in the way men and women react to the same circumstances. This is less a psychoanalytic discussion than a philosophical essay on behavior. It is written with tolerance and good humor and should be widely enjoyed. It contains much wisdom besides.

Lover's Point. By C. Y. Lee. 249 pages. Cloth. Farrar, Straus & Cudahy. New York. 1958. Price $3.75.

An interesting melancholy novel is written by a Chinese-American who has had some success with his first book, *The Flower Drum Song.* The book is a variation on the theme of unrequited love. Though the author consciously seems not to understand the dynamics, his description of characters is correct.

The Road to Inner Freedom. By Baruch Spinoza. D. D. Runes, editor. 209 pages. Cloth. Philosophical Library. New York. 1957. Price $3.00.

This is a re-issue of the famous *Ethics,* written in the year of Columbus' discovery of the New World. It is interesting to re-read the well known work, and to observe the progress made since in evaluation of emotions.

The Preservation of Youth. By Moses Maimonides. 92 pages. Cloth. Philosophical Library. New York. 1958. Price $2.75.

Moses ben Maimon, known as Maimonides, lived as an exile from his native Spain in the Egypt of Saladin during the twelfth century. (He refused an offer of King Richard the Lion-Hearted to become court physician of England.) This small book was written after Saladin's death, for his son who was then sultan. It was translated from Arabic to Hebrew in medieval times, and the present English translation is by an American psychiatrist.

The book covers the rules of physical and mental health that Maimonides thought would be valuable to the sultan. Some of them are as acute observations today as they were when they were made; some are amusingly antique. For an example, Maimonides thinks one should "enter the bath" once in 10 days but that it is all right to take a bath "even" every day, provided one only washes and leaves. Maimonides warns against abuse of wine but says its benefits are many if it is taken in the proper amount and adds "old people need it most."

On another psychiatric topic, he remarks: "the interest of most men in intercourse is well known. ... The informed already know that intercourse hurts most people, except the few whose temperament shows that a small amount of it will not hurt them. ... we have seen the convalescent who has had intercourse and died the same day... Whoever wishes to remain healthy should chase the idea of intercourse from his mind as much as he can."

The reviewer doubts if there is a psychiatrist anywhere who would not enjoy this small book.

The Geography of Witchcraft. By MONTAGUE SUMMERS. 623 pages including index. Cloth. University Books. Evanston, Ill. 1958. Price $7.50.

Montague Summers was an exceedingly learned priest of the Roman Catholic Church with a firm belief in the literal devil and in the actuality of witchcraft. The present book is an American printing of a volume first published in England in 1927. It covers the history and manifestations of witchcraft in ancient times, in medieval and early modern Europe and in New England. This is a fascinating book in which to read at random, and it is presumably a reliable source.

The author's incidental comments are delightful. Of Elizabeth I, he remarks, "a lewd old strumpet might be acclaimed as a Virgin Queen." He comments on the Salem witchcraft episode, that "The Genevan ministers had neither the spiritual nor the practical knowledge necessary to deal with so dark and difficult a task. Naturally they blundered woefully and abundantly." Obviously, Father Summers believes that his own church would have done better. It might be noted that he thinks there was an actual witch coven in Salem, although innocent persons were also convicted. This book should be indispensible in any library covering demonology—and with apologies to the author—folklore and superstition.

New Dimensions of Learning in a Free Society. By EDWARD H. LITCHFIELD. 18 pages. Paper. University of Pittsburgh. No price given.

This is an address, given by Dr. Litchfield on the occasion of his inauguration as twelfth chancellor of the University of Pittsburgh in 1957. It is along friendly-conventional lines, defining the functions of a university in five points: imparting of existing knowledge, discovery of new knowledge, application of knowledge, integration of knowledge, and assistance in the development of the student as a complete human being.

The National Association for the Advancement of Colored People. By WARREN D. ST. JAMES, Ph.D. 252 pages. Cloth. Exposition. New York. 1958. Price $4.00.

This is what appears to be a fairly objective study of the National Association for the Advancement of Colored People by a sympathetic Negro social scientist. Dr. St. James discusses the association as a pressure group, analyzes the ways in which it has exerted pressure, and takes up its relationship with other pressure groups. He obviously feels that, pressure group or not, it has been a worth-while organization, although he thinks it has failed to reach "the masses of Negroes." His volume includes a history of the NAACP, a description of its organization and operation, discussion of its policies, some case studies of NAACP action, and appendices covering its organization, its constitution, its bylaws, branches and other pertinent matters. This is an excellent reference book.

The Secret Lore of Magic. By IDRIES SHAH. 316 pages including index. Cloth. Citadel. New York. 1957. Price $5.00.

This book is a translation of the principal books of the great magicians of ancient and medieval times. The dust-jacket says that nothing even approaching a survey like this has ever before been made in any language. Unfortunately, it does not set forth the qualifications of the author. This text covers everything from pacts with the devil to prescriptions for talismans or spells. A note of interest to psychiatry is given by Albertus Magnus; "the tooth of a mare being put upon the head of a man being mad, delivereth him from his fury." Besides Albertus Magnus, material attributed to Agrippa, Solomon and Aristotle will be found here. Anybody interested in magic and witchcraft will value this book.

The March of Conquest. By TELFORD TAYLOR. 460 pages including index. Cloth. Simon and Schuster. New York. 1958. Price $7.50.

This volume differs from the usual report of German military action in having been written, not by a German commander, but by the chief counsel for the prosecution at the Nuremberg war-crimes trials. It is a very careful report of Germany's 1940 war in the west, culminating in the conquest of France. As such, it is of primary interest to the student of military tactics and strategy.

However, Taylor goes extensively into the question of why a victorious nation bungled so much and so thoroughly. The failure of organization at the top to make proper estimates and to assure proper co-ordination is of interest to anybody concerned with organization and communication.

The author observes that "the fruits of conquest in the West rotted in the victor's hands." While this is not a depth study of the psychology responsible, it is an excellent outline of the numerous major mistakes of Nazi psychology. Serious study of the sources of those mistakes—partly Hitler himself, of course—would require another and a different book. Perhaps Mr. Taylor could be persuaded to collaborate with a specialist on such a book some day.

The Road To Happiness, and Other Essays. By PERCY JOHN NEWTON. 153 pages. Cloth. Chapman & Grimes. Boston. 1955. Price $3.50.

This is a group of essays covering the main phases of human behavior. Through them all runs the author's belief that even though the Christian life may not be perfect, it does make possible the meeting of the ills and the evils of modern life. It is the author's contention that nothing can be perfected, except through spiritual fraternalism, by which mankind can be bound into a fortunate, happy and harmonious whole of reality.

Epilepsy. By TRACY J. PUTNAM, M.D. 190 pages including index. Paper. Lippincott. Philadelphia. 1958. Price $1.25.

This small volume is written by an eminent neurologist, primarily for patients. He also expresses the pious hope that patients' relatives and friends, lawmakers and contributors to clinics and research will read it as well. It is a clear description of what epilepsy is, of what is known about its causes, and of present methods of control. Dr. Putnam's conclusions are, of course, on the whole hopeful. Even the nonspecialist is well aware of the great advances made in recent years toward helping epileptics to live normal and comfortable lives. His book is simple and well organized and has an adequate index. It is 190 pages of as good mental hygiene as this reviewer has seen in a long time.

The Psychology of Human Differences. By LEONA E. TAYLOR. 508 pages. Cloth. Appleton-Century-Crofts. New York. 1956. Price $6.00.

This book, based on emphasizing statistical significance, and directed toward prospective students of psychology, devotes exactly one and three-quarters pages to psychiatric-psychoanalytic theory of character types, simplifying the latter to near unrecognizibility.

Health Supervision of Young Children. A Guide for Practicing Physicians and Child Health Conference Personnel. 180 pages. Paper. The American Public Health Association. New York. 1955. Price $2.00.

This is a wonderfully-written book with much appeal for all workers in the child health field. The two aspects of health, the physical and psychological, are well integrated.

Envy and Gratitude. By MELANIE KLEIN. 91 pages. Cloth. Basic Books. New York. 1957. Price $2.75.

In the usual "mixture as before," Mrs. Klein explains for the thousandth time her ideas on early infantile aggression, omitting any masochistic elaboration. The purpose of the book is obscure: Those familiar with Kleinian theories, will find nothing new; those unfamiliar with Kleinian theories will not understand it.

Human Relationships. By ELEANOR BERTINE. 237 pages. Cloth. Longmans, Green. New York. 1958. Price $4.50.

A Jungian physician attempts to explain human relationships "in the family, in friendship and in love." Her book is a constant permutation of the slogans, "animus, anima, archetypes, collective unconscious," and it will win little applause from psychiatrists of other than the Jungian school.

Symbolism. Its Meaning and Effect. By Alfred North Whitehead. 88 pages. Cloth. Macmillan. New York. 1958. Price $2.50.

Symbols and their necessary role in society are discussed in this very small book by the late Alfred North Whitehead, who was one of the world's great philosophers and mathematicians. Society, Whitehead feels, is made possible only by the possession of a common store of symbols. He thinks when a revolution destroys a sufficient amount of this common symbolism "society can only save itself from dissolution by means of a reign of terror." He feels that a free society must both maintain its symbolic code and revise it fearlessly when necessary, in the interests of an enlightened reason. This reviewer would add: If it only could! This is a short, readable discussion and it is recommended to the attention of all who are interested either in individual or social psychology.

A Dangerous Woman. And Other Short Stories. By James T. Farrell. 160 pages. Cloth. Vanguard. New York. 1957. Price $3.50.

This is a collection of perceptive and sensitive stories about little, unimportant people. The author does not analyze his characters so much as expose them (Here they are! See the things they do!) with his customary sympathy for their futility and hopelessness.

Rage on the Bar. By Geoffrey Wagner. 272 pages. Cloth. Noonday Press. New York. 1957. Price $3.50.

Rage on the Bar is a bitter and satiric indictment of British colonial resistance to native demand for self-government. The scene is a lovely Caribbean island, inhabited by a full complement of upper-class British "types." It is interesting.

Murder of a Wife. By Henry Kuttner. 182 pages. Paper. Permabooks. New York. 1958. Price 35 cents.

This fourth murder mystery by the late Henry Kuttner (pseudonym) is something of an improvement over the three previous ones. He manages to make his psychoanalyst and the matter of psychotherapy plausible and accurate. The story is readable.

The Threshing Floor. By Joseph Coyne. 315 pages. Cloth. Putnam's. New York. 1956. Price $3.95.

This is an "inspirational" novel, a rambling story of a Catholic community in New England, showing how the people—clergy and laity alike—although beset by all the vicissitudes of human life, joy and sorrow, sickness and health, wisdom and folly, do manage to fulfill "the will of God."

Facts and Theories of Psychoanalysis. Third Edition. By IVES HENDRICK, M.D. 403 pages including index. Cloth. Knopf. New York. 1958. Price $6.00.

The third edition of this book should prove to be as popular as the other two. It is one of the best introductions to the theory and application of psychoanalysis. Compared to the second edition, much of the third has been revised, expanded and rewritten. Included in the book is an excellent glossary.

Something for the Birds. By THEODORE S. DRACHMAN, M.D. 190 pages. Cloth. Crown. New York. 1958. Price $2.95.

This one is a lurid who-dun-it with an exceptionally clever plot. But the author's style of writing leaves much to be desired, and he has filled the book with too many technical medical terms for understanding by the general reader.

The Stopped Clock. By JOEL TOWNSLEY ROGERS. 311 pages. Cloth. Simon & Schuster. New York. 1958. Price $3.50.

That this author is a master of suspense and surprise is proved again in this story, as it was in his first chiller, *The Red Right Hand*. But his characters are not real people, rather puppets who are dangled this way and that, through one horror after another until the reader is sick of the whole bloody mess.

Seeds of Murder. By JEREMY YORK. 190 pages. Cloth. Scribner's. New York. 1958. Price $2.95.

This is not a mystery tale. It is a novel of suspense, and one of the best. The story concerns a man's desire for revenge, and his plan to make a small boy responsible. The result is a wildly frightening tale. Only the author's good insight into character, and his careful writing place it above an ordinary lurid melodrama.

The Lasting South. L. D. RUBIN and J. J. KILPATRICK, editors. 205 pages. Cloth. Regnery. Chicago. 1957. Price $5.50.

A peculiar mixture of sentimentality, unreconstructed sectionalism, and half-understanding that the past is dead, characterize this compilation of 14 studies on the "modern" South. There is little to be gained from it.

Cartoons for Men Only. SANDY NELKIN, editor. 160 pages. Paper. Popular Books. New York. 1958. Price 35 cents.

This collection includes a goodly proportion of such usual psychiatric subjects as sadism, masochism and the war between the sexes. It will not enlighten very many but it should amuse anybody.

Fear: Contagion and Conquest. By JAMES CLARK MOLONEY, M.D. XII and 140 pages. Cloth. Philosophical Library. New York. 1957. Price $3.75.

The principle section of Moloney's thesis is that "emotionally stable, normally integrated, emotionally mature adults develop by being afforded properly measured mothering by relaxed loving mothers throughout the first three to five years of their lives." This, of course, is very much in accord with most current belief; and from here, the author traces his belief that non-neurotic mothers made tense by *real dangers* can innoculate their babies with their own (normal) fears and thus cause their babies to grow into neurotic adults.

The author investigates many situations and many cultures. His studies of the Okinawans are perhaps the most important, and the result is an impressive array of supporting evidence. In spite of much discussion, the significance of this study in the present state of world tension cannot be completely assessed; but this reviewer believes that many in the field of psychiatry and the allied disciplines will find it of value.

The Road to Mayerling. By RICHARD BARKELEY. 293 pages including index. Cloth. St. Martin's Press. New York. 1958. Price $6.00.

Sixty-nine years ago a young man and a girl who loved him were found, done to death by violence, in a hunting lodge at Mayerling in Austria. The young man was the 31-year-old crown prince of the Austrian empire. His death rocked Europe and may have changed the course of world history. Prince Rudolph was a liberal, a strange scion of an autocratic tree. There seems very little doubt that he wished and hoped to make a great liberal power of his father's autocratic empire. There also seems very little doubt that he killed himself and the woman who loved him because of frustration of his plans and lack of moral strength to carry on with his liberal ambitions. It is possible also that he was involved in a Hungarian revolutionary project that his father would have found treasonable.

In *The Road to Mayerling* the author attempts to trace, through Rudolph's personal history, the factors and the motivations which led to the tragedy. He has however a most extraordinarily difficult task. All the power of the most autocratic royal family in Europe was used to suppress the facts, and Rudolph's mental state and inner motivations can, in all probability, never be arrived at. What is certain is that Mayerling was the end of a liberal road and the beginning of a path toward the world wars and revolutions of the twentieth century. Dr. Barkeley is an experienced historian and he has probably done as well with his difficult material as anybody could do. With all its lacks, his book, therefore, is of value both to the student of modern history and to the scientist interested in what can be traced of a most unfortunate young man's motivations.

Anatomy of a Murder. By ROBERT TRAVER. 437 pages. Cloth. St. Martin's Press. New York. 1958. Price $4.50.

This book, at the head of every best-seller list in the country for many weeks, is simply a readable account of a fictional murder trial with an insanity defense. It deals largely with a rape, which led to the murder, and which is described in detail several times as the defense attorney develops and presents his case. This is doubtless one reason for the novel's great popularity, for the writing is not distinguished, and some of the characterization is poor, although the account of the trial is swift, meticulously accurate, and exciting.

Careful description of the machinations before and during the trial and the parts played by the various participants make this book of considerable general merit. As a study of forensic psychiatry and the widely differing attitudes toward mental states of psychiatry and the law, it is excellent. The author, a well-known Michigan attorney, has had very good advice indeed on the psychiatric aspects of his story; and the narration should be of interest to every member of the psychiatric profession. It presents the medico-legal problem and the psychiatric viewpoint to a far wider circle of readers than will ever see either the professional medical or professional legal literature on the subject.

The reviewer admits to cavilling, but he was made uneasy by what appears to have been a lapse by the author concerning military law, and he finds that others acquainted with military law have made the same observation. Article 133 of the *Unified Code of Military Justice* (Article 95 of the old *Articles of War*) is a provision more than broad enough to insure that an officer of the army meets his legitimate financial obligations.

Bibliography of Group Psychotherapy 1906-1956. By RAYMOND J. CORSINI and LLOYD J. PUTZEY. 75 pages. Paper. Beacon House. Beacon, N. Y. 1957. Price $3.00.

This bibliography contains entries of all known books, chapters in books, journal articles and theses concerned with group psychotherapy published from 1906 through 1956. Libraries will find this booklet a valuable addition to their reference shelves.

The Double Bed. By EVE MERRIAM. 160 pages. Cloth. Cameron Associates. New York. 1958. Price $3.50.

There is a good deal of common sense and a good deal of uncommon insight in this rather unromantic verse-portrait of marriage. It has both literary and psychological interest, although this reviewer would have been happier if the author had omitted some physiological cataloguing that is reminiscent of Walt Whitman.

CONTRIBUTORS TO THIS ISSUE

MELITTA SCHMIDBERG, M.D. Dr. Melitta Schmideberg, has been a member of the International Psycho-Analytic Association since 1933. She was training analyst and lecturer to the British Psychoanalytic Society from 1938-1945; professor of psychiatry at Adelphi College from 1949 to 1951. She was psychiatrist to the Institute of Scientific Treatment of Delinquency in London from 1933 to 1949. Dr. Schmideberg is chairman of the executive committee and founder of the Association for Psychiatric Treatment of Offenders in New York City. She is an associate editor of the *Archives of Criminal Psychodynamics*, and is the author of various books and scientific articles on psychoanalytic subjects, including the treatment of psychotics, borderline cases, psychopaths, offenders, delinquents and children. Among her books are *Children in Need* and *Short Analytic Therapy*. She has contributed previously to this journal.

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At the end of 1929 he joined the staff of Brooklyn State Hospital as an intern and through successive promotions attained the rank of assistant director. In 1947 he was acting medical inspector of the department of mental hygiene. From April to October 1950, he was acting assistant commissioner. He then became director of Syracuse Psychopathic Hospital.

He returned to Brooklyn as director on November 1, 1952. He is clinical professor of psychiatry at the State University College of Medicine at New York.

He has written articles on metrazol treatment of schizophrenics, problems of the aged psychotics, and on rehabilitation of the mental patient.

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NEWTON BIGELOW, M.D. Editor of this QUARTERLY, Dr. Bigelow is also director of Marcy (N.Y.) State Hospital. He was commissioner of mental hygiene for New York State from 1950 to 1954. Born in London, Ontario in 1904, Dr. Bigelow is a graduate of the medical school of the University of Western Ontario. He joined the New York State hospital system after serving a general internship, and has been in the state hospital service ever since. He has been senior director of Marcy since 1945 and editor of this QUARTERLY since 1947, except for a leave of absence from both positions during his commissionership. Dr. Bigelow is author or co-author of a number of scientific papers published in this and other professional journals. He has always been actively interested in professional education, teaching at the State University of New York, Upstate Medical Center, Syracuse. He is a diplomate in both neurology and psychiatry of the American Board of Psychiatry and Neurology.

CONSTANCE M. BARWISE, M.D. Dr. Barwise received her medical degree from Western Reserve Medical School in 1928. After internship, she was resident pediatrician at Grasslands Hospital, Valhalla, New York. In December 1933 she entered the New York State hospital service, first on the staff of Pilgrim State Hospital and later on that of Marcy State Hospital. Since February 1954 she has served as assistant director (clinical) at Marcy, where she has also taken part in several research projects. Dr. Barwise is married to Richard F. Binzley, M.D., assistant commissioner of the New York State Department of Mental Hygiene.

BERTRAM P. KARON, Ph.D. Dr. Karon received his A.B. from Harvard College in 1952, his M.A. from Princeton University in 1954, and his Ph.D. degree in 1957 from Princeton University. He held a research fellowship at the Educational Testing Service at Princeton University from 1952 to 1955. He then served an internship (as a psychologist) with Dr. John N. Rosen, working on the "direct analytic" technique of psychotherapy, after which he returned to Princeton University as a U.S. Public Health Service Research Fellow. From February to June of 1958 he served as senior clinical psychologist at Annandale (N.J.) Reformatory, and now holds the position of public health research fellow, National Institute of Mental Health, Department of Psychology at Princeton.

KAREL PLANANSKY, M.D. Dr. Planansky obtained his Ph.D. degree in physical anthropology at the Faculty of Science, Charles University, Prague, in 1928. In 1933, he graduated from the Medical Faculty of the same university. As a member of the staff of the Institute of General Biology, Medical Faculty of Charles University, he was engaged in research in medical genetics and demography. During the war, he served as a medical officer with the Royal Air Force. Between 1948 and 1953, he was on the staff of the Department of Medical Genetics, New York State Psychiatric Institute, and was appointed Research Associate in Psychiatry, College of Physicians and Surgeons, Columbia University. Since 1953, he has been a full-time staff physician at the Veterans Administration Hospital, Canandaigua, New York. He has been appointed instructor in psychiatry (part-time) at the Rochester University School of Medicine and Dentistry. He is a member of the American Association of Physical Anthropologists, American Society of Human Genetics, and American Psychiatric Association.

JOHN L. CAMERON, M.B., Ch.B., D.P.M. Dr. Cameron is a graduate of the Faculty of Medicine of the University of Glasgow, Scotland in 1950. He received his D.P.M. from the Royal College of Physicians and Surgeons in 1952. His basic medical training was received in the Victoria Infirmary of Glasgow. Dr. Cameron had psychiatric training in the psychotherapeutic unit at Killearn Hospital, Stirlingshire, Scotland, and in Glasgow Royal Mental Hospital. For two and one-half years he was the research assistant in chronic psychoses in the Department of Psychological Medicine, University of Glasgow. At present he is a clinical administrator at Chestnut Lodge, Rockville, Md.

A. ESTERSON, M.B., Ch. B. At the time the paper of which he is coauthor was written, Dr. Esterson was a member of the schizophrenia research unit, department of psychological medicine, University of Glasgow.

ROBERT JEAN CAMPBELL, III, M.D. Dr. Campbell is chief of the psychiatric inpatient service of St. Vincent's Hospital, New York City. He is an instructor in psychiatry at the College of Physicians and Surgeons, Columbia University, and holds other lecturing and consultant positions. A graduate in 1944 of the University of Wisconsin, he was a teaching fellow in the department of psychology there before he obtained his medical degree from the College of Physicians and Surgeons in 1948. After a general internship, he served a psychiatric residency at the New York State Psychiatric Institute and was later chief psychiatrist of the sex offender project at Sing Sing Prison. He served for two years in the army, and was senior clinical psychiatrist at the New York State Psychiatric Institute for three years before taking his present position. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. Dr. Campbell was a collaborator in the 1953 supplement of Hinsie and Shatsky's *Psychiatric Dictionary* and is the author of several psychological and psychiatric scientific papers.

EDWARD M. PICKFORD, M.D. Dr. Pickford received his M.D. from Johns Hopkins University, School of Medicine in 1925 and his M.S. (Surgery) from Washington University, St. Louis, in 1927. From 1929 to 1948 he was in the private practice of medicine and surgery in Washington, D.C. In 1948 he became staff physician at Foxborough (Mass.) State Hospital, remaining there until 1951 when he became medical director of the Alcoholic Rehabilitation Division, District of Columbia Department of Health. In 1956 he became a staff psychiatrist at the Veterans Administration Regional Office, Providence, R.I.

CHARLES TAFFEL, Ph.D. Dr. Taffel received his Ph.D. from Indiana University in 1952. He later served with the Veterans Administration as a chief clinical psychologist in Providence, R.I., and as co-ordinator of training in Brockton, Mass. At present he is director of the Palm Beach County Child Guidance Center in West Palm Beach, Fla. He is certified in psychology in Florida, Massachusetts and Rhode Island and is a member of various professional organizations.

ANTHONY HORDERN, M.B., Ch.B. (Edinburgh), M.R.C.P. (Edinburgh), M.R.C.P., D.P.M. Anthony Hordern was born in 1925, and he was graduated in medicine from the University of Edinburgh in 1947. After general internships, he was in general practice in the north of England and later served as flight lieutenant in the Royal Air Force Medical Branch in Germany. He entered psychiatry in 1951, working at St. Clement's Hospital Observation Ward, London, and later at Claybury Mental

Hospital, Essex. Subsequently, he was employed for four years in the Department of Psychological Medicine of the University of Durham at Newcastle on Tyne. He became a diplomate of psychological medicine of the University of London in 1952, a member of the Royal College of Physicians of Edinburgh in 1954, and a member of the Royal College of Physicians of London in 1955. Receiving a Fulbright Traveling Scholarship in 1956, he worked for two years in the Psychiatric Institute of the University of Maryland, latterly as instructor there. He is currently employed as a visiting scientist at the National Institute of Mental Health, Bethesda, Maryland. He published a paper on chemical abreaction in 1951.

ROBERT SEIDENBERG, M.D. Dr. Seidenberg was born in Syracuse, N. Y. in 1920. He was graduated from Syracuse College of Medicine and served in the army medical corps from 1944 to 1946. He received his residency training at Syracuse Psychopathic Hospital. Thereafter he was graduated from the Institute for Psychoanalysis of Chicago in June 1956.

He is a past president of the Syracuse Psychiatric Society, a founding member of the Western New York Psychoanalytic Group, and a member of the Chicago Psychoanalytic Society. He is at present engaged in the practice of psychiatry and psychoanalysis in the city of Syracuse where he has clinical affiliation with the Upstate College of Medicine at Syracuse.

He is married and has three daughters.

HEINZ L. ANSBACHER, Ph.D. Dr. Ansbacher received his Ph.D. in psychology at Columbia University in 1937. He is professor of psychology at the University of Vermont, Burlington, Vermont. Co-editor with Mrs. Ansbacher, who also has a Ph.D. in psychology, of *The Individual Psychology of Alfred Adler,* he is also editor of the *Journal of Individual Psychology.*

NEWS AND COMMENT

ERNEST JONES, M.D., PSYCHOANALYST, DIES AT 79

Ernest Jones, M.D., Freud's first pupil from England, and for many years the leader of British psychoanalysis, died in London on February 11, 1958, at the age of 79. He had had several heart attacks and had suffered from cancer for several years.

Outside of psychoanalytic circles, Dr. Jones was best known for his monumental three-volume *The Life and Work of Sigmund Freud,* the third volume of which appeared in 1957. The first two were published in 1953 and 1955. Dr. Jones wrote not only as a pupil but as a lifelong friend of the founder of psychoanalysis. He was a young neurologist in London when he became interested in Freud's theories and went to Vienna in 1907 for the first of many journeys for study, and later for friendship. He commenced the practice of psychoanalysis in London after the first visit.

Dr. Jones was instrumental in the introduction of psychoanalysis to the western hemisphere when he was appointed professor of psychiatry at the University of Toronto in 1908, and when, in 1909, he accompanied Freud for the latter's lecture at Clark University, Worcester, Mass. The following year Dr. Jones helped found the International Psycho-Analytical Association and he was permanent honorary president of this organization at the time of his death. He was a founder in 1911 of the American Psychoanalytic Association and was the first secretary of it. He was the principle founder in 1913 of the British Psycho-Analytical Society and was its president for many years. He was honorary president, at his death, of both the American and British organizations and of the Institute of Psycho-Analysis of Great Britain.

Dr. Jones was not only a close friend, as well as a student of Freud; he was instrumental in helping Freud leave Austria for England after the Nazi coup in 1938. He also established a fund to help other refugee psychoanalysts and their families.

Born in Llwchwr, Wales, Dr. Jones attended the University College of South Wales and Monmouthshire at Cardiff and the University College of London, receiving his medical degree at the age of 21. Besides his life of Freud which is considered the authoritative work on the subject, he wrote five volumes of papers on psychoanalysis, and books on *Treatment of Neuroses, The Problems of Hamlet, Essays in Applied Psycho-Analysis,* and *Hamlet and Oedipus,* in addition to numerous monographs and scientific papers on neurology and anthropology. Dr. Jones was an active man physically, became an expert figure skater in middle age, and wrote a book on figure skating. Other hobbies were rose-growing and chess.

HUMAN BEHAVIOR RESEARCH URGED

Expanded research in human behavior to improve international relations and strengthen national defense was urged early in February by a temporary group of 15 social scientists organized by Dr. James G. Miller, director of the Mental Health Research Institute at the University of Michigan. Ralph W. Gerard, professor of neurophysiology (psychiatry) of the same institution, is another member, as is John C. Whitehorn, director of the department of psychiatry of the Johns Hopkins University Medical School.

GROUND BROKEN FOR NEW RESEARCH LABORATORY

Ground has been broken for a basic research laboratory at Ardsley, N.Y. by the pharmaceutical division of Geigy Chemical Corporation. It will be the division's first such center in the United States, and is being built as part of an intensive program to expand research facilities launched by the parent company in Basle, Switzerland.

DECREASE IN MENTAL PATIENTS REPORTED

For the second successive year a decline in patient population in the nation's public mental hospitals has been reported, in a survey released jointly by the American Psychiatric Association and the National Association for Mental Health. The survey covers the year 1957.

DEPARTMENT OF MENTAL HYGIENE TITLES CHANGE

The title of the New York State Department of Mental Hygiene's Office of Publications and Public Relations has been changed to the Office of Mental Health Education and Information, effective April 1958. Mrs. Margaret M. Farrar is director of the office.

In the Community Mental Health Services, the unit headed by Dr. Philip Wexler will be known henceforth as the Unit of Professional Education and Training in Mental Health. Dr. Wexler now has the title of director.

NEW INTENSIVE TREATMENT BEGINS AT POUGHKEEPSIE

New York State Department of Mental Hygiene Commissioner Paul H. Hoch, M.D., has announced the opening of the state's third intensive treatment unit for newly admitted geriatric patients at Hudson River (N.Y.) State Hospital, Poughkeepsie. The new unit is designed to treat patients with psychiatric conditions who are over the age of 65 and can possibly benefit from intensive therapy. Two other units were set up in 1956 at Central Islip and Buffalo state hospitals.

PHILIP R. LEHRMAN, M.D., PSYCHOANALYST, DIES AT 62

Philip R. Lehrman, M.D., one of the pioneers of psychoanalysis in this country and widely-known writer, teacher and clinician, died suddenly at his home in New York City on February 4, 1958 at the age of 62.

Born in Europe, Dr. Lehrman was brought to the United States with his family at the age of nine. A precocious student, he was graduated in medicine at 22 from Fordham University in February 1918. Soon after his graduation, he joined the staff of St. Lawrence (N.Y.) State Hospital under the superintendency of Richard H. Hutchings, M.D. From Dr. Hutchings and from Dr. A. A. Brill, whom he met while he was at St. Lawrence, he became interested in psychoanalysis.

In 1920, Dr. Lehrman became attending neurologist at the Vanderbilt Clinic in New York City and two years later was appointed visiting physician at Manhattan (N.Y.) State Hospital where he taught psychoanalytic principles to the resident staff. He visited Vienna for the historic psychoanalytic teaching seminar in 1925 and returned in 1928 for a personal analysis with Freud. At this time, he took motion pictures of Freud, his family and associates, which are considered priceless records today.

Dr. Lehrman joined the New York Psychoanalytic Society and Institute in 1924 and his background as a neurologist served him well in the succeeding years in battling against constant attacks then being made by non-analytic psychiatrists on psychoanalysis. He was one of the original instructors of the New York Psychoanalytic Institute in 1931, and he remained on the institute faculty until his death. He was a former president of the New York Psychoanalytic Society and Institute and had been secretary of that organization for more than 10 years. He had been chairman of the section on psychoanalysis of the American Psychiatric Association and was a charter member and president of the New York State Hospital Medical Alumni Association.

Dr. Lehrman's personality and ability as a teacher recruited many students to psychiatry, including two nephews and a cousin. Dr. Lehrman served in the army during both world wars. He was the author of numerous psychoanalytic publications and for 20 years before his death was on the editorial board of the *Psychoanalytic Review*. He leaves his widow, a son, Howard, a daughter, Mrs. Lynne Weiner, and two grandchildren.

BERNARD HOLLAND, M.D., APPOINTED TO EMORY

Bernard Holland, M.D., an associate editor of this QUARTERLY, has been appointed professor and chairman of the department of psychiatry at Emory University (Ga.) He plans to continue some of the research there in which he has been interested in the past. He has been principal research scientist (internal medicine) at the New York State Psychiatric Institute.

DR. MALAMUD TAKES RESEARCH JOB

William Malamud, M.D., psychiatrist and leader in mental health research, has accepted the position of research director for the National Association for Mental Health, effective September 1. In accepting the new position, Dr. Malamud is resigning as a chairman of the division of psychiatry at the Boston University School of Medicine and as psychiatrist-in-chief at the Massachusetts Memorial Hospital.

SAPER NAMED NEW DIRECTOR OF PSYCHOLOGICAL SERVICES

The appointment of Bernard Saper, Ph.D., as director of psychological services in the New York State Department of Mental Hygiene has been announced by Commissioner Paul H. Hoch, M.D. Dr. Saper, who assumes his duties July 1, succeeds Dr. Elaine F. Kinder who is leaving the position to devote full time at Rockland State Hospital to a follow-up study of brain-operated schizophrenic patients.

THREE VOLUMES OF INDEX OF PSYCHOANALYTIC WRITINGS

Three volumes of *The Index of Psychoanalytic Writings* have been published, and the fourth is expected to be ready by November 1958. Additions or corrections for this fourth volume should be sent either to International Universities Press, 227 West 13th Street, New York 11, N. Y. or to Dr. Alexander Grinstein, 18466 Wildemere Avenue, Detroit 21, Mich.

FELLOWSHIPS IN PSYCHIATRY ANNOUNCED

The Smith, Kline & French Foundation has announced a $100,000 grant to the American Psychiatric Association, to continue the foundation's fellowships in psychiatry through 1960. These fellowships were established in 1955 and are administered by a committee named by the American Psychiatric Association. Henry Brill, M.D., assistant commissioner in the New York State Department of Mental Hygiene, is a member.

RUSSIAN TRANSLATION INSTITUTE FOUNDED

Foundation of an institute to make Russian scientific material available in English has been announced. It is a nonprofit organization, to be known as the Pergamon Institute, and will be located in Washington, D.C. In announcing the formation of this foundation, its executive director, I. R. Maxwell, quoted Sir Alexander Todd as stating that only about 2 per cent of English scientists can read Russian. Authoritative sources in the United States, says Maxwell, agree that this figure applies to American scientists as well.

SOCIETY MEETINGS AND ACTIVITIES FOR 1958

Two international gatherings are among the important psychiatric meetings scheduled for 1958. The IV International Congress of Psychotherapy is scheduled for September 1 to 7 in Barcelona, Spain. Its theme is "Psychotherapy and Existential Analysis." The Collegium Internationale Neuro-Psychopharmacologicum is meeting in Rome from September 9 to 12. Further information can be obtained from the American secretary, Herman C. B. Denber, M.D., Manhattan State Hospital, Ward's Island, New York 25, N. Y.

The American Orthopsychiatric Association held its thirty-fifth annual meeting in New York City in March. At the annual meeting of the American Psychosomatic Society, in Cincinnati in March, Milton Rosenbaum, M.D., was elected president; Morton F. Reiser, M.D., was elected secretary-treasurer. The sixteenth annual meeting of the society will be in May 1959 in Atlantic City.

The American Psychiatric Association is holding its annual meeting in May in San Francisco. In connection with that meeting, the Society of Biological Psychiatry is presenting the first A. E. Bennett Neuropsychiatric Research Foundation Award to Dr. Max Fink of Hillside Hospital, New York. The spring meeting of the Academy of Psychoanalysis is in San Francisco on May 11. It includes a symposium on the "family approach" in psychoanalytic therapy.

Workshops in the Rorschach technique have been scheduled for the summer and fall of 1958. Workshop A is from July 20 to August 1 in Pacific Grove, California. Its topic is "The Rorschach Method of Personality Diagnosis and Other Projective Techniques." Workshop B in Los Angeles, October 6 to 11, has as its subject the study of projective techniques as used with children.

The fifth annual meeting of the Academy of Psychosomatic Medicine, scheduled for New York City October 9 to 11, has as its subject "The Psychosomatic Aspects of Internal Medicine." The meeting is open to members of all scientific disciplines, including psychologists, social workers and nurses.

The Society for the Scientific Study of Sex will hold its first annual meeting in New York City on November 8 at the Barbizon Plaza Hotel. Details may be obtained from Robert V. Sherwin, 1 East 42nd Street, New York 17, N. Y.

The third annual conference of the New York State Association of Community Mental Health Boards is being held May 18 through 20 at the Hotel Syracuse, Syracuse. The program theme is "Community Mental Health Programs—Relationships and Resources."

The International Conference on General Semantics is scheduled for August 24 to 27 under the auspices of Mexico City College. It is spon-

sored jointly by Mexico City College, the Institute of General Semantics and the International Society for General Semantics.

The fifth annual meeting of the Academy of Psychosomatic Medicine is from October 9 to 11 at the Park Sheraton Hotel, New York City. The theme of the meeting is "The Psychosomatic Aspects of Internal Medicine."

The National Association of Music Therapy is conducting its ninth annual conference in Cincinnati from Thursday, October 30 through Saturday, November 1. Special interest group meetings feature the conference, which concludes with a concert by the Cincinnati Symphony Orchestra Saturday evening.

The Postgraduate Center for Psychotherapy announces the second series of international seminars in October. The general topic is "Implications for Psychiatry of Recent Researches on Animal Behavior."

An International Conference on Insulin Treatment in Psychiatry is scheduled for October 24 and 25 at the New York Academy of Medicine, New York City. It has been arranged for the purpose of presenting recent advances in the basic aspects and clinical uses of insulin.

The mid-winter meeting of the Academy of Psychoanalysis will be held December 5 at the Roosevelt Hotel, New York City.

NORTH SHORE HOSPITAL LECTURE SERIES ANNOUNCED

The North Shore Hospital's ninth annual lecture series will be on "Emotional Forces in the Family." The lectures are scheduled for the first Wednesday of every month from October 1958 through June 1959 at the hospital, 226 Sheridan Road, Winnetka, Illinois. All members of the medical profession and allied professional personnel are invited to attend.

PSYCHOANALYTIC PSYCHOTHERAPISTS MEET

The first membership meeting of the Council of Psychoanalytic Psychotherapists is being held in New York City at the United Nations Plaza on May 24. The purpose of the organization is to bring together in one group individuals who come originally from three disciplines—psychiatry, clinical psychology and psychiatric social work.

NEW CONNECTICUT MENTAL HEALTH COMMISSIONER NAMED

Dr. Wilfred Bloomberg of the Southern Regional Educational Board staff of Atlanta, Ga., has been named new commissioner of mental health for Connecticut.

DR. WILLIAM FREDERICK LORENZ DIES AT 76

Dr. William Frederick Lorenz, professor emeritus of psychiatry at the University of Wisconsin, and widely known professionally for research in the use of carbon dioxide in the treatment of psychoses, died in Madison, Wisconsin on February 18, 1958 at the age of 76. As a young man before World War I, Dr. Lorenz had served on the medical staff of Manhattan (N.Y.) State Hospital. Dr. Lorenz served in both the Spanish-American War and in World War I, when he commanded an army field hospital in France. He had been active in veterans' rehabilitation projects since World War I.

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HEATH IS TENTH HUTCHINGS LECTURER

Robert G. Heath, M.D., Chairman of the department of psychiatry and neurology, Tulane University School of Medicine, is giving the tenth annual lecture in memory of Richard H. Hutchings, M.D. His topic is "Research Studies in Schizophrenia."

The lecture is scheduled for the auditorium of the College of Medicine, State University of New York, Upstate Medical Center, Syracuse, on October 6, 1958. The series of lectures is made possible by subscriptions from friends and colleagues of Dr. Hutchings who died in October 1947. He was editor of this QUARTERLY and had taught for many years at the medical school in Syracuse. Dr. Hutchings had been superintendent of Utica (N.Y.) State Hospital and of St. Lawrence (N.Y.) State Hospital and was president of the American Psychiatric Association in 1938-39.

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1958-59 GRADUATE PSYCHOANALYSIS PROGRAM ANNOUNCED

The Downstate Medical Center, College of Medicine, of the State University of New York, in Brooklyn, has announced that the teaching year for its graduate program in psychoanalysis will run from September 29, 1958 to June 6, 1959. Before matriculation, students who have received conditional acceptance must satisfactorily complete one academic year of personal analysis under a training analyst assigned by the director of the graduate program. A certificate of training in psychoanalysis will be awarded to students satisfactorily completing the four-year course and judged by the faculty to have attained the requisite competence to carry out independent psychoanalytic therapy. The four-year curriculum includes didactic instruction, analytically-derived psychotherapy supported by case seminars and supervisory sessions, and supervised clinical practice in psychoanalytic therapy.

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